Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 7.538 **Physician** May 2007 20 EMORY JACKSON BALDWIN, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number) Examiner Plata harly Medical MD (en If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 12-12-1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 6. Sex Social Security Number Months **Funeral** Days Hours 1 ₹ M 2 □ F Maryland 81 220-12-3249 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Director Indianhead Mary land Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 20640 U.S.A. 3900 Marvin Drive must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mantal Hygiene. Important; If tenn 27 is marked other than "natural", or items; any Injury or other traumatic event, the Medical Examiner mu 11 Marital Status 1 Never Married 2 X Married  $\mathcal{L}_{MOV}$   $\mathcal{R}_{\alpha}\mathcal{M}_{MO}$  Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes, Give Specify: White 2 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Arther College (1-4or 5+) Elementary/Secondary (0-12) Myers Plumbing Plumber 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Bertha Maske Emory Jackson Baldwin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2404 Dargan School Road, Sharpsburg, MD 21782 Clara E. Chaney - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/25/2007 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery : 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 M01491 hande 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ne /Medical Due to (or as a consequen of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed and use as the burial-tran Division or Vital Records, P.O. Box 68760名 Due to (or as a consequence of) physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be d Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed 1□ Yes 2☑No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 \_\_Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the fu investigation 2 ☐ Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0056949 harelde

Registrar

3

Kamakshi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ais

La Plata, MD

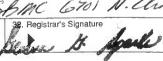
#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** В. Brown Margaret 5:40 рМ 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 166-26-0358 89 Pennsylvania June 18, 1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County show 23a or 28a-f shovust be notified at 1 ☐ Yes 2 ☑ No Md. Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 4 Tyler Falls Court Unit I USA Examiner must Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ White 3 N Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Apartment Rental Agent traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vincent Coleman Sue Leposky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Brown∕ Son 3601 Greenway #702 Baltimore, Md. 21218 Department of Health Important: If item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Parkwood Cemetery 5-21-07 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rego wort /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 6 as the burial-tran Due to (or as a consequence of): physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 → To 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 **2** No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. I Director: / 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

W

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

30. Name and address of person



f death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

6701 N. Charles St. Balto md 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Ma v ľ9, **Physician** 2ďď7 Leo Bedsau1 7:50am Garnett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2105 Mt. View Road Howard Marriottsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours ountry) Coui V A 1√2 M 2□ F 1944 216-42-8187 63 Jan 4, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marriottsville MD Howard 2 should be filed within 72 hours after death with the Is and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2105 Mt. View Road 21104 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 2 1965-70 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Printer Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bedsau1 Elizabeth Hodge Arthur Leo Erma 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun once. Mrs. Linda M. Bedsaul (Wife) 2105 Mt. View Rd., Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 5/23/2007 Marriottsville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 42U Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 1∐ Yes 2[ Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this ours after death.

neral Director: After this filled in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours a

To the Funeral I

completely filled 0

> State Registrar

29b. Signatore and title of certifier

completed cause of death (Item 23a) (Type, Print)

150

29c. License number

<+ Pn-1 P1

D40854

29d. Date signed (Month, Day, Year)

12007

			1 - For State Registrar	State of Maryland / [	Department of Health and I Certificate of Death		ene 007	1550;
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
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	Examir		4e. Fecility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Death	)	4c. County of Deal	h
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	Funeral		5. Social Security Number 6. Sex	IN OFFICE	thday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign
Dr.	Director		Usual Residence of Decedent	1 / 8		100TILL	720 INOI	th Carolina
	yland		10a. State 10b. County	10c. City, Tow	t and			10d. Inside City Limits
	Mar Be-f st	io	mar Anne A.	rundel A	naporis			1 ☑Yes 2 ☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
	23a	rai	1911 E. Copela	nd St.	21401		05	A
	tems terms	Funerai		12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ∕No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	lack
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<u>la</u>	should be nd Mental marked imatic ev	To	Jessie	melven	Kema	il	Davis	<i>2</i>
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (Ty)		. Mailing Address (Street and Number or Ru	ral Route Number, C	City or Town, State.	Zip Code)
	1 and 2 Health em 27		Michele S, Ka	rdall-daughter i	911 E. Copeland St	4	US, MD.	
0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	comete	Disposition (Name of ry, crematory or other place)	Date 20	c. Location - City or	Town, State
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Baltimore	permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service/License		22. Name and Address of Facility	270 Red	HILTON	Fass
	40240		222 Part Early Individual of compile	cations that caused the death. Do	not enter the mode of dying, such as cardiac			6, md, 2,229
			shock, it reart failure. List only or Immediate souse (Final	e cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arres	L,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	CVA				2 W/4
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		-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):			geau,
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Box	leath certific attending p I for use as t	an/J	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 DEctopic pregnancy		23d. Date of del	
		sici	1 🗆 Yes 2 No 9 🗆 Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month	Day Year
P.O.	that the de ed by the detached		Part II. Dther significent conditions con	tributing to death but not reculting in	the underlying cause group in Part I	23e Did toba	co use contribute to	the cause of death?
ds,	law requires that the as been signed by th 2 should be detache	d by	Turrit, butter digitimating con	thousing to doubt but not resulting if	Title dildeliying cabse given iii r ait i.		2 □ No 3 □ Pr	
Ö	requ been shoulk	etec						
Vital Records,	The law	Completed				24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
a	ician: Th certificate rector, pag	e Co	25 Man ages referred to modical			1 ☐ Yes 2 <b>/</b> 5	No 1 ☐ Yes	2 No
	Physician: r this certific ral director,	00	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1   Inpatient 2   ER/Ou	Othar	th <i>(Check only one)</i> ome 5 ☐ Resident	extons (c-	DTRS -
o	g Phya er this eral dii	n: To	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how		RESIDELLE
<u>o</u>	Attending I r death. actor: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	njury Work? M 1 ☐ Yes 2 ☐ No			
Division of	er der racto by th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Stree City or Town,	et and Number or Ru State)	ıral Route Number,
	rs afte al Dir	Certification:		building, old. (oppolity)		ony or rount, t	Jiaio	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the caus	se(s) and manner as	stated.
	To the hwithin 2. To the Complete	Med	one)	and marner stated.				
1	To vit	-	29b. Signature and title of certifier	26.4	29c. License number	( 2 8	. Date signed (Mont	a, Day, Tear)
	1	Į,	JAN Chan D	MAMM	y v'	סכד	11 by 21	1001
)	•	7/	AA	pleted cause of death (Item 23a)	DEFENSE HIGHWA	ANNA	DOWIS WA	DLIYUI
0	Sta	te	31. Date filed (Month, Day, Year)	32. Magistrar's Signature		1 / 1017	4 - ( ) 7 / (	0 - 101
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** E. Ciotola Grace May 15, 2007 1:25 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Nursing Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min. Yrs **Director** 88 24, 1919 171-01-3806 Jan. Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Rossville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Paula Place, Apt. 1B 21237 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 2 Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ George Krapf Minnie Roth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank W. Ciotola (Son) 7 Paula Place, Apt 1B, Rossville, Md. 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 05/19/ 2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, Maryland 21236 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): weeks Examiner ocardon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.
4 hours after death.
4 hours after death.
4 hours after this certificate has been signed by the attending physician and the first or 1 hours after this certificate has been signed by the attending physician and the set in the trunctual director, page 2 should be detached for use as the buriar-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Year Day 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSD(Q 1 ☐ Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charies ST TONUN MOZIZOY HARLES , wo

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:35 A M 2007 May 17, Robert V. Carr, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Days 1 X M 2 □ F Yrs Mary Tand 06-25-1918 88 218-09-9957 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21015 1322 S. Tollgate Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify 3K Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Copenhaver George R. Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bel Air, MD 21015 Cathy Bowden (Daughter) 1322 S. Tollgate Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Emory Church Cemetery May 21,2007 Upperco, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DISEASE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner once.

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 2300 DULANEY VALLEY, RD.

32. Registrar's Signature

death with the Maryland

Maryland 21215-0036

Baltimore,

burial-tra the attending physician cate nas been signed by page 2 should be detach this

The law requires that the death certificate be execute or Attending 24 hours after death Funeral Director:

CARR

Vital Records,

Hospital

within 2.

		d			<u> </u>			
IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ī	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 ☐ Ectopic				23d. Date of delivery Month Da	ay Year
Part II. Other significant con	nditions co	ntributing to death but not res	ulting in the underlying	cause given in Pa	ırt I.		use contribute to the	***
						24a. Was an autopsy performed?	prior to comp death?	y findings available letion of cause of
25. Was case referred to me	edical			26. PI	ace of Death (	(Check only one)		
examiner? 1 ☐ Yes 2 <b>X</b> No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	OOA Other; 4	Nursing Hom	e 5 Residence	6 X Other (Specify)	HOSPICE
27. Manner of Death 1 X Natural 5 □ Pe 2 □ Accident	ending vestigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?		3d. Describe how inju	ry occurred	
	ould not be etermined	28e. Place of injury - At he building, etc. (Specific	ome, farm, street, fact fy)	ory, office	28	Bf. Location (Street ar City or Town, State	nd Number or Rural F e)	loute Number,
29a. Certifier 1X Cer (Check only one) 2 Med	tifying Phy dical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurration and/or investigat	ed at the time, date on, in my opinion,	and place, ar death occurre	nd due to the cause(s d at the time, date an	and manner as stated place, and due to the	ed. ne cause(s)

29c. License number

721

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

State Registrar

b

DHMH 17 Rev 1/2001

		-	State of Maryland / Department of Health and  1- State Registrar  Certificate of Death		Reg. No.	16507
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of De	Day Year	
	/Medic Examin	al -	Samuel S. Cofelice  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Difference of the SPITAL  4c. City, Town, or Location of Difference of the SPITAL	may eath	2/ 200, 4c. County of Dea	
	Funeral Director		216–16–0647 81 Yrs.	Hrs. 8. Date of Bi Ain. (Month, Da 08/24/	rth 9. Bi ay, Year) Ca.	rthplace (State or Foreign country) nada
	n the Maryland r 28s-f ehow	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Maryland   Baltimore   Catonsville Manor			10d. Inside City Limits 1 Tyes 2 No
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 21207		10g. Citizen of What C United Sta	
036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28s-f ehow int, the Medical Examiner must be multified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII 1 ☐ Yes 2 No Specify:	? (Specify Yes or Nuerto Rican, etc.)	Black, Wh	encan Indian, ite, etc. White
Maryland 21215-0036	filed within 72 hours Hygiene. ther then "natural", int, i'm Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  6  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Groundskeeper	working	16b. Kind of Busines School Sy	•
yland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Burnatic event.	To Be C	Pasquale Cofelice Teres	sa Salvato		
	s 1 and f Health Item 27 other tr		19a. Informant's Name/Relationship (Type, Print)  Theresa Cofelice / Wife  20a. Method of Disposition  Burial 2 □ Cremation 3 □ Removal Irom State  19b. Mailing Address (Street and Number of 5911 Carroll Street  20b. Place of Disposition (Name of cemetery, crematory or other place)	Baltimor Date	ce, Maryland 20c. Location - City of	d 21207 or Town, State
Baltimore,	permit. Page: Department or Important: If eny injury or		4 Donation 5 Other (Specify)  21. Signature of Funeral Sovice Licensee  22. Name and Address of Facility  5311 Fdmondson Av  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car	David J. W Venue Balt	imore, Mar	al Homes PA
3760, €	Physician // Medical Examiner prize	ilcal Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to for as a consequence of):	tion y dise	last	Un Un Duin
P.O. Box 68	the death certificate be ex t the attending physician ched for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of d Month	lelivery Day Year
Vital Records, P.	Attending Physician: The law requires that the death certifical r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Completed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Status Post Cooking Stewn Diacement  Revolution of the Cooking Stewn Diacemen	24a. Wa	s an 24b. Were prior to death	Probably 4 Unknown autopsy lindings available o completion of cause ol
of Vita	Physician: this certific at director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2 EP/Outpatient 3 DOA Cther 4 Nursin		sidence 6 Other (S	pecify)
Division o	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident 3 Surcide 4 Homicide Surcide Actions determined Surcide Surcide Actions Surcide Surcide Actions Surcide Su	28f. Location	Show injury occurred  (Street and Number or own, State)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce		place, and due to the occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier  29c. License number	maryla	129d. Date signed (Mo	nth, Day, Year)
	1211		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5. Cat	on Ave.	Daltimore,
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature			2166

07-03744 Earl

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2007 16503

Cornish, III	-	State of Maryland / Department of Freath and Montal Hygiene  - For State  Certificate of Death  Reg. No
	F	Registrar  2. Date of Death  3. Time of Death
Physicia – Examir	11/4	FACI S (ORNISH III May 16, 2007 1940 IIIS
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death
		Sinai Hospital Baltimore N/A
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Process) Foreign
Director		219-17-1825   1 × M 2 F   2 / Yrs.   Months Days Hours Min.   MARCH 9, 1986   Country) MARY AND
	H	Usual Residence of Decedent 10d Inside City Limits
any	Ī	10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No
show nce.	5	MARVIAND NIA DAZITAORE CITA
faryla 28a-f 1 at o	Director	10e. Street and Number
the Na or		1022 KICHNOR AVENUE 212 Was December of Hispanic Opinio? (Specify Yes or No- 14. Race - American Indian, Black,
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever In U.S. If Yes specify Cuhan Mexican, Puerto Rican, etc.) White, etc.
death or ite	ᆵ	1 Yes 2 No
s after	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No specify: Speci
36 hin 72 hours after e. than "natural", edical Examiner		15. Decedent's Education (Specify Only Ingriest grade Compiletos)  during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4 or 5+)
36 in 72 han '	ple	Dunc GRILL COOK MC DONALD TAST TOOD
5-0036 iled within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once	Be (	FARI S. CORNISH JR. GLENICE D. PARTLOW
D 21, should b and Men 7 is mar	٩	19a. Informant's Name/Relationship (Type, Print.)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 12 sho th and 127 is		THELMA PARTIOWGRAND MOTTER 10 2 KICHNOR HVE WALL I HOKE MULLING TOWN, State  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of Town, State
tore, MD 21215-0036 siges 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. 1: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner		20a. Method of Disposition  1   Burial 2   Cremation 3   Removal from State  M
F 6 5 5 1		4 Donation 5 Other Specify: O MT - SPACE CHIER TO A O LANGUAGE OF
Baltir permit. 1 Departm Importa		22. Name and Address of Fability BROWN JR. FUNERAL HOME.
<b>©</b> 27 7 11.		28a Part I. Entit the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Approximate Interval Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart approximate Interval Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart approximate Interval Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart approximate Interval Part of the disease, or complications that caused the death.
ysician		// failure. List only one cause on each line.
/ledical Examiner		/mmediate Cause (Final disease a. Gunshot wound to back or condition resulting in death)  Due to (or as a consequence of):
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	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):
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Records, P.O. Box 68760,  The law requires that the death certificate be execate has been signed by the attending physician.	led	IF FEMALE: 23d. Date of delivery
Box 6876( he death certificate the attending phy hed for use as the b	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
ath ce	Sici	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  9 Unknown
he de hed f	훒	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
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<b>S, –</b> quires en sig	fed	24a. Was an autopsy findings available autopsy prior to completion of cause of
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Division of Notal or Attending Phours after death.	Cortification.	3 Suicide 6 Could not be determined (Specify) Sidewalk
To the Hos within 24 h	Modical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To To	3	and marmer stated.  29c. License number  29d. Date signed (Month, Day, Year)
		b. A. Older May 17, 2007
0		30. Name and address of person who completed cause of death (item 23a)
3		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature
Reg	istra	
DHMH 17 Rev	1/200	ORIGINAL ORIGINAL

		Ctate of Manyland / Department of Health and	•	
		State of Maryland / Department of Health and  1- State Registrar  Certificate of Death		21117 185119
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/Med Exam	dical niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County of Death
LAGII		Manor Care Nursing Home handalls	tain	baltimore
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Months Days Hours Min		9. Birthplace (State or Foreign Country)
Directo	or	Usual Residence of Decedent	10.29.19	131 1910
land ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mary a-f-ah	jo	MD Baltimore Gwynn Ogh		1 ☐ Yes 2 No
th the	lrec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
ath wi	Funeral Director	Ce210 florus moad 21207		134
er de	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, specify Cuban, Mexican, Puel	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
irs aft		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 1 Yes 2 No Specify: Year or Dates:		Specify: Black
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permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is	- Suce	21. Signature of Funeral Service Licensee 22. Name and Address of Facility V C	zughn C. Cire	ne funera service
D &&E &	а	Naughn C. Greene 8728 Liberty Rd Pho	andallstain	MO 21133
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory arrest,	Approximate Interval Between Onset and Death
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ding Th.: After	io t	27. Manner of Death  1 Natural 5 Pending (Month, Day Yeer)  28a. Date of Injury 28b. Time of Injury 4 Work?  2 Accident investigation  28b. Time of Injury 4 Work?  1 Yes 2 No	20d. Describe flow	injury occurred
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s afte	Certification:	4 Homicide building, etc. (Specify)	City or Town, S	rare)
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical (	29a. Certifier (Check only (Ch		
tha H hin 24 tha F	Med	one) and manner stated.		Date signed (Month, Dey, Year)
L I C		29b. Signature and title of certifier  29c. License number  D 0059107		25 - 21 - 207
16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		41- 6-1
12		KAZU UMA ZIU BUSINESS CENTER DRIVE RENTER	25Town	MD 21136
	State	SAZU UMA 210 BUS, NESS CENTER DRIVE RENTER  31. Date filed (Month, Day, Year)  MAY 2 2 2007  MAY 2 2 2007		
Regis	strar	MAY 2 2 2007 Access AF Access		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 18 Year Month 200 **Physician** 10:44 nas Hanes 10a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 00 Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Buthmore MD 7. Age (In yrs. last birthday) **Funeral** Min. Hours 1 M 2 F 9 Months Days Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □No Tores Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 20 No Specify 1 ☐ Yes Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) alloring 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ana2 19b. Mailing Address (Street and Number or Rural Route Number, Cay or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) tore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ICremation Forest 5 ☐ Other (Specify) 4 Donation FORESTHILMD 21050. 22. Name and Address of Facility 3 New port 21. Signature of Funeral Service Licensee Evans Fue al Chapel Jenve or complications that caused the eath. Do not enter the mode of dying, such as cardiad or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Ö 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate has ral director, page 2  $2\square N$ 1□ Yes 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 21 No 1 Inpatient 1 ☐ Yes 28d. Describe how injury occurred 28b. Time of funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After Division 5 ☐ Pending investigation DAN A. 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) 30. Name and address of person who Registrar's Signature 31. Date filed (Month, Day, Year) State 2 Registrar

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DAUGHERTY

GERTRUDE Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. important: If item 27 is marked other than "na any injury or other traumatic event than "na once." DONORUE

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

/Medical **Examiner** The law requires that the death certificate be execute and burial-trar Division or Vital Records, P.O. Box 68760. the attending pl for use as t certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
ATT THE STATE OF THE 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 1:07 PM Physician 2007 Gertrude B. Donohue /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Samantan Hospital Good 8. Date of Birth 1913 (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕱 F 93 9/15<del>/2007</del>Maryland 212-01-5793 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Parkville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 2620 Burridge Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Mamed Specify: white 1 ☐ Yes 2 XNo ģ 3 Widowed 4X Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) office clerical work 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Grupp Charles F. Munk ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2620 Burridge Rd. Parkville, MD 21234 Pat Kozlouski- daughter 20b. Place of Disposition (Name of cemetery, crematory of other place)
Parkwood
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition ₩₩Burial 2 Cremation 3 Removal from State Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Rd. Parkville, MD<sub>21234</sub> Evans Funeral Chapel & Cremation Services 21. Sign. of re eral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumomo 10551ble Watron **Physician** disease or condition resulting in death) Due to (or as a consequence of): Blee 61 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 5 Other (specify) I Yes 2 No 9 Tillnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pothy 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 2 ER/Outpatient 1 patient ို 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05/19/2007 RES 000 MD ANV n 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Baltmore, MD 21239 HOJINA (Jaurar Khanna Registrar's Signature 31. Date filed (Month, Day, Year) MAY 2 2 2007 State Registrar

DHMH 17 Rev 1/2001

completely filled in by the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16 Month 5 **Physician** Year 07 2205 MI LUSEL /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMONE N/A of UNIU. ANTERNO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours Months Min. 1 XM 2 ☐ F 216-62-0487 51 Yrs Director July 26,1955 West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2X No Directo Maryland Baltimore Fort Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 9415 Todd Avenue P.O. Box 426 21052 United States Funeral ural", or items 2 Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced White Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Production Manager Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd A. Davis Olive G. Cox ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9415 Todd Ave. Mrs. Theresa L. Davis (Wife) P.O. Box 426 Ft. Howard, MD 21052 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 5/21/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. transostu 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that cansed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earbine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUNONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Mapner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation (Month, Day Year) Natural Injury 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 JEFF 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 GARKIK 51 5 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

		1	State of Maryland / Department of Health and N  - State Certificate of Death		4001	16513
			1 Decedent's Name (First, Middle, Last)	2. Date of Death	Day Yeer	3. Time of Death
	Physicia /Medic		MURNA Leona Charles DAVIS	Month y	14,2007	
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	/	4c. County of Death Baltin	
			Johns Hopkins Bay view Care Center Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry)
	Funeral Director		580-01-8233 1 M 2 K F 70 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, ) 2/3/1937	(ear) Virg	in Islands
-	p .	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	/aryla	20	MD Baltimore Parkville			1 □Yes 🎗 🗓 No
	28e-	rect	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28e-f show	Funeral Director	2805 Berwick Avenue 21234		JSA	
	tems tems	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	e, etc.
20	n 72 hours after death with the Marylan "natural", or items 23a or 28e-f show circal Examiner invest be inclifted at	by F	1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☐		Specify: Af	ro- Caribbean
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Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			Zip Code)
	s 1 and f Health item 27 other tr			ltimore,	Md 21234 Dc. Location - City or	Town, State
altimore,	0 0	- 63	1 Rurial 2 Cremation 3 Demoval from State	/2007 B	altimore, Ma	rvland
	permit. Page Department of Important: If any injury o	1	21. Signature of Funeral Service Licensee / 22. Name and Address of Facility	5305 Ha	arford Roa	d
ñ	Per Supplied of the Control of the C		Leonard J. Ruck, In	ıc Baltir	nore, Mary	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ARRHYTHMIA			MINUTES
	Examiner		Due to (or as a consequence of):  CORONARY ARTERY DISEASE			YEARS
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			YEARS YEARS
	ecutec and transi	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  C. RENAL FAILURE  Due to (or as a consequence of):			YEARS
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Rox	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)		23d. Date of de Month	livery Day Year
o.	that the de led by the a detached t	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown			
S,	res tha igned be del	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Revieweral Vascular Disease Infected	23e. Did tob	acco use contribute to	o the cause of death? robably 4 □Unknown
ord	w require been si should i	eted	Below knee amoutation, Anemia	24a. Was ar		utopsy findings available
Records,	hast ge 2 s	Completed	below thee ampulation, memia	autopsy	prior to death?	completion of cause of
ta	sician: The certificate hir	0		ath Check onlone		2010
of Vital	Physician: r this certifica ral director, I	To B	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing H			ecify)
0 0	ding Pl After ti funera		27. Manner of Death  1	28d. Describe ho	w injury occurred	
Division	after death. Director: After	Certification:	2 Accident a livestigation   2 Accident   3 Suicide   6 Could not be   28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Str City or Town	reet and Number or R	tural Route Number,
á	in the	Certi	4 Homicide Getermined building, etc. (Specify)	City of Town	, State)	
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date 2 Medical Examiner: On the basis of examination and or other and the basis of examination and ot	e, and due to the ca urred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of contilier 29c. License number	25 L	d. Date signed (Mon	th, Day, Year)
)	1		W > 20438	ر د	17 14,	2007
İ	)		30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print) William Greenough 5505 Hopkins Bayview Circle	e Balti	more Mo	ryland zizzt
_	_	1				- /

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (Fint, Middle, Last) Month 40pm done **Physician** na /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Eachity Name (If not institution, give street and number) Examiner utheru Baltimore htwooo Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 ☐ M 2 🕱 F Yrs 266 32 2188 Director Aug 22, 1924 FL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nach of Health and Mental Hygiene. The same the other than "natural", or Itams 23a or 28a-f show ant: if item 27 is marked other than "natural", or his requires any or other transmitter requires. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Completed by Funeral Director Baltimore White Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21161 2617 Garrett Rd 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Lab Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Nunn Clarice Adams 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2617 Garrett Rd. White Hall, Who 21161 City or Town, State Ada L. Stambaugh/daughter 20b. Place of Disposition (Name of cempetery, crematory or other place Wiseburg Methodist Church 20a Method of Disposition Lepartment of H In portant: If its any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 24 May 2007 White Hall, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Female Lemmon Funeral Home of Dulaney Valley Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HEART a CONGESTIVE Physician resulting in death) /Medical Examiner FAILURE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) Examine ASTRO INTESTINAL BLEEDINZ that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, an/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Physicia 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Upknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🔲 No the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: Wursing Home Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation **Y**-⊠Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier DO053 150 Souple MD

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Shewnmale

MAY 2 2 2007

31. Date filed (Month, Day, Year)

Supte 9650 Sanhapo nd Suitelio Columbia

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ElKen berg **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Age (In yrs. last birthday Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Year) Days 215-30-8162 1 1 M 2 □ F 75 May 5, 1932 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State a or 28a-f show t be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 206 Charter Oak Place r than "natural", or items 23a the Medical Examiner must b 21014 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4or 5+) Elementary/Secondary (0-12) Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 s oud be fil of Health an Mental H f Item 27 is marked ott William Eikenberg Marie King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marge Eikenberg (wife) 206 Charter Oak Place BE1 Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of H 1 N Burial 2 □ Cremation 3 □ Removal from State Important: If May 21,2007 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical as the l 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s 2∐No certificate Fo the Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 | Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GRUENE ST BATTIMONE, MD. 0

Registrar DHMH 17 Rev 1/2001

State

CAMONI (

31. Date filed (Month, Day, Year)

2

32. Registrar's Signature

07-03731 Robert Evans

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 16517 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	Rec	or State	Certifica	ate of	Deam		Re 2. Date of Death	9. No	3.	Time of Death
Physician/ Examiner	1. 1	Decedent's Name (First, Middle,Last)	vert Evans				Month May 16, 20	Day 107	Year	0125 hrs
	4a.	Facility Name (if not institution, give	street and number)	4	b. City, Town, or L Baltimore	ocation of Death	1	4c. Cour	nty of Death	-
	Ļ	University Hospital	7. Age (In yrs. last birt	hday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of Birt	h(MM/DD/Y)	YYY) 9. Birthp	lace (State or
Funeral Director		Social Security Number 6. Sex 12-02-0355 1	y 2 F 2	4 Yrs.	Months Days	1			Foreign	ry) Maryland
		a. State 10b. County	. 10c. City, Town	or Locati	on o					Od. Inside City Limits
ow any		aryland N	IA I		Be	altimore			1	Yes 2 No
Maryland 28a-f show d at once, rector	10	e. Street and Number			10f. Zip Code		1	09. Citizen o	f What Country	γ? Δ
he Maryland or 28a-f sh iffied at once	'`	1303 MyHe 1	Ave.		ó	21217			USI	4
ath with the liems 23a or ast be notifie		. Marital Status	12. Was Decedent Ever in U.S.	13. Wa	s Decedent of His es, specify Cuban	panic Origin? ( S	Specify Yes or No to Rican, etc.)		Race - America Vhite, etc.	n Indian, Black,
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. 40 other than "natural", or items 23a or 28a-f sho is, the Medical Examiner must be notified at once to completed by Funeral Director	1	Never Married 2 Married	Armed Forces?  1 Yes 2 No		Yes 2 No			Sner	Hr. Blace	K
ral", o	ا a		If Yes, Give Year or Dates: 163	1 Deceder	of's Usual Occupat	tion (Give kind of	f work done	16b. Kind o	of Business/Inc	dustry
hours natur Exam		15. Decedent's Education (Specify on Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	nost of working life	. DO NOT use re	etired)	Ral	Himan	Depot
36 nin 72 fran than dical	2	Elemental y/Secondary (5 12)	,	Was	te Mar	ragemen	<u> </u>	1		2901
5-0036 ed within 72 hours after lygiene. other than "natural", the Medical Examiner. Commissed by '	5 1	7. Father's Name (First, Middle, Last)				18.Mother's Nar	ne (First, Middle, anie C	Maiden Surn	name)	
9 13 14 15 D	ă l	Robert Evans		Oh Mailin	g Address (Stree					Zip Code) 21117
MD 21 12 should 12 should th and Me 127 is may umatic ev	2 1	9a. Informant's Name/Relationship (T		12	Belladon	ra Ct	· Owing	5 Mill	15, Mai	yland
al al d	2	Kimberly King  Oa. Methed of Disposition		of Dispo	sition (Name of ce		Date	20c. Loca	tion - City or T	øwn, State
altimore, mit. Pages I a spartment of He iportant: If ite	1		Removal from State	atory or o	(emeter	n 5	124107	Bat	timore	Maryland
Baltimor permit. Pages Department of Important: If injury or othe		Donation 5 Other Specify  1. Signature of Funeral Service Licen		22.	Name and Addres	of Facility Pa	KerFu	recal	Home	P.A. 121229
Balti permit. Departir Imports		Kenn 1	an (In/	35	12 Fre	derick	Ave	BaHin	rore, N	Apprøximate Interval
ysician	2	3a. Part I. Enter the disease, or comp	lications that caused the death. Do ach line. Complications	not enter	the mode of dying	, such as cardia s associat	c or respiratory at -ed with re	rest, snock,	airwav	Between Onset and Death
de dical Examiner		mmediate Cause (Final disease a.	disease and left ve	ntrici	ılar hyper	rophy of	heart		all may	
Zammer	1	or condition resulting in death)	Due to (or as a consequence of):							
	ا او	Sequentially list conditions, f any, leading to immediate	Due to (or as a consequence of):							
	티	cause. Enter Underlying Cause Clisease or injury that initiated	Due to (or as a consequence of):							
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3760, ficate be g physic s the bur	S 1	F FEMALE:	23c. If yes, outcome of pregnan	су			eonancy	1	onth Celivery	Day Year
687 certific	jan/	3b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of death	-	Fetal death 3 Other (Specify)	Ectobic pro	gilarioy			
that the death certify hed by the attending detached for use as	<b>S</b>	1 Yes 2 No 9 Unknow	n 9 Unknown				00 Di	I tabaggo ugo	o contribute to	the cause of death?
O. E at the at the d by the tachec		Part II. Other significant conditions	contributing to death but not resu	Iting in the	e underlying cause	e given in Part I.				pably 4 Unknown
ords, P.C. w requires that as been signed to should be deta	g o								24b. Were au	itopsy findings available
ords v requ s been should	je te						au	topsy rformed?	prior to death?	completion of cause of
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed							s 2 No	1 🗸 Y	es 2 No
Vital Rec hysician: The this certificate al director, page	Bec	25. Was case referred to medical examiner?	Hospital:			Other	eck only one) ursing Home 5	Residence	ce 6 Othe	er:
Vit hysic rthis o	0	1 Yes 21 INU	, <u>C</u>	R/Outpation		njury at Work?		e how injury		
n of \ding Phy		27. Manner of Death  1 Natural 5 Pending	(Month, Day,Year)		1	Yes 2 V No	ATV one	erator o	habillo:	with vehicle
ivision or Attend after death. Director:	cati	2 X Accident Investiga	28e. Place of Injury - At hom	5 <b>:00</b>	nm treet, factory, offic	e building, etc.	28f. Locatio	n (Street and	Number or R	ural Route Number, City
Divi	Certification:	3 Suicide 6 Could no determin	ot be				Name Ave	n, State) P. @ Not	rthern Pl	ww. <u>Baltim</u> ore
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	2	00 0 00		death oc	courred at the time	, date and place	, and due to the o	ause(s) and	manner as sta	ited.
thin 2 the l	edical	one) 2 Medical Examin	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	or invest	igation, in my opin	iion, death occur	red at the time, d	ato and piec		onth, Day, Year)
F. 2 E. 8	Me	29b. Signature and title of certifier				ense number			17, 2007	,,1,,
×		90031-1	eeghin		0.	C.M.E. 		Avidy		
1		30. Name and address of person wh	o completed cause of death (Item 2 Assistant Medical Examir	3a) ner 1	11 Penn Stree	et, Baltimore	, MD 21201			
v		Tasha Greenberg MD.	La Sp. Julyada Signa Mr.		out					
	iate trar	31. Date filed (Month, Day, Ytter) 20	O/ June 10	19						

			For State Registrar	tate of Mai	ryiand		tificate of		ר	F	Reg. No	200	7	100	518
	Physicia		1. Decedent's Name (First, Middle, Last)  Ronald J. Fir	ın						Date of Dea Month May		<sup>ay</sup> 200 <sup>7</sup>	ear	3. Time of 9:00	P M
	/Medic Examin		4a. Facility Name (If not institution, give stree Laurel Regional Hos	_			4b. City, Town, or Laure		of Death		4c. County of Death Prince George			eorge's	3
34 46	Funeral Director		5. Social Security Number 6. Sex 1 1 M	~	(In yrs. las		If Under 1 Year Months Days		er 24 Hrs. 8. Min. M	Date of Birti (Month, Day lay 17	h			place (State o	
	yland how at		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						1	I0d. Inside Ci	
	e Ma 8a-f s	cto	Maryland Montgome	У		Burto	nsville							1 ☐ Yes	2[ <b>X</b> [N0
	th with the 23a or 2 st be no	Funeral Director	3719 Airdire Court				10f. Zip Code 208	66			10g. Ci	itizen of Wha USA	it Cour	itry?	
2-0030	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Markar Gladas	Was Decedent Ev Armed Forces? 1			Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2🎇 No	lispanic C an, Mexic Specif		/ Yes or No- an, etc.)	-	14. Race - American Indian Black, White, etc. Specify: White		etc.	
1213-0-C	2 should be filed within 72 ho and Mental Hygiene. is marked other than "natu aumatic event, the Medical	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	on mpleted) College (1-4or 5+		(Give life. L	lent's Usual Occup kind of work done DO NOT use retired gement	ation during mo d)	ost of working		Departmer Transport		nt Of		
0	filed Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Last)	•			0	18. Mot	her's Name <i>(F</i>	irst, Middle,	Maide	n Surname)			
ומחם	Aental Aental rked tic ev	To B	John Finn					1	Alice S	Saladi	n				
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	permit. Pages Department of H Important: If Ite any Injury or of once,		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State			sition (Name of natory or other place matory I			1			•	Maryla	and
מש	permit. Depart Import any in		21. Signature of Funeral Service Licensee Thomas Gregor	~		26	remation 199 Frede	ssst rick	Tety Of Road E	Mary Baltim	lan ore	id, Inc	i. Zlar	nd 212:	28
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of							espiratory a	rrest,	•		Approximat Interval Bet Onset and I Over 3	te tween Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Osteo Sa  Due to (or as a			Jaw with	Meta	stasis				(	Over 3	<u>Year</u>
	Examiner	_	Sequentially list conditions, b.	-											
1	ted nsit	Examiner	Sequentially list conditions, if any leading to include the cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a	conseque	ence off:									
08/00,	ificate be executed g physician and as the burial-transit	al Exar	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):									
20	ificate g phys as the	edical	d								- т				
C. BOX	the death certifi / the attending ched for use as	Physician/M	IF FEMALE: 23c. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal d	death 3	Ectopic pregnanc Other (specify)	:у				23d. Date of Month			Year
rds, F	requires that the de een signed by the a rould be detached f	by	Part II. Other significant conditions contrib	outing to death but	t not result	ing in the u	nderlying cause giv	ven in Par	t I.	23e. Did t				the cause of o	
Hecord	s b	Completed								24a. Was auto perfo 1⊟ Yes		pride:	or to co ath?	opsy findings ompletion of c	available cause of
VITal	Physician: The lathis certificate had director, page 2	Be C	25. Was case referred to medical examiner?					26. Pla	ce of Death (C						
- -	Physic this cal dire	은	T res 2 10	pital: 1 ☑ Inpatien 28a. Date of Injury		R/Outpatier 28b. Time o	IL 3 DOA		Nursing Home			6 Other	• •	fy)	
	iding P h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury	Wo	rk? ]Yes 2		1. Describe	now in	jury occurred			
DIVISION	i or Atter after deal Director	Certification:	OF Could and by	28e. Place of injuit building, etc.	ry - At horr . <i>(Specify)</i>	ne, farm, sti	reet, factory, office		28f	Location ( City or To	Street a wn, Sta	and Number ate)	or Rur	ral Route Nur	nber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examiner		examination										(s)
	To the To the To the Comple	Me	29b. Signature and title of certifier	Land.			29c. Licens	se numbe	er		29d. D	Date signed (	Month,	, Day, Year)	
	,			100	_2,	- N	D002	24721			N	May 20	, 20	007	
	25		30. Name and address of person who comp					000	_	,		200			
	St.	ate	Syed A. Sadiq 1433 31. Date filed (Month, Day, Year)	1			ad <u>Suite</u>	208	Laurel	, Md 2	2078	308			
	Regist		MAY 2 2 200	1 Deces	w D	ire	edi)								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 19<sup>ay</sup>, 200<sup>r</sup>7<sup>a</sup> 3:10 A. M Dorotha Scott Foster 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore County Parkton 1039 Mt.Carmel Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Sept. 06, 1921 Guston, Kentucky 1 □ M 2 1 F Yrs. 85 405-14-8247 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Maryland | Baltimore County Parkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21120 1039 Mt. Carmel Road 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 1 ☐ Yes 2 ☐No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper 12 N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maytie Beatrice Jones Fletcher Mercer Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Husband) Mr. Vernon Royston Foster Parkton, Maryland 21120 1039 Mt. Carmel Road May Date 21 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium,Maryland 21093 23a. Part. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 14 monus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes

**Physician** /Medical Examiner

ō

Department of Important: If any Injury or once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with

Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or iten

altimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

attending physician and for use as the burial-transit ed by the detached been signed by should be detact certificate funeral After neral Director; A death. hours after

The law requires that the death certificate be executed

Box 68760.

P.O. P

Division or Vital Records,

the Hospital or Attending Physician:

Examine Physician/Medical Completed by Be မ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

(Check only one)

29a. Certifier

5 Pending investigation

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number D414-06 29d. Date signed (Month, Day, Year)

May 21 97 2007

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES STREET MADITU CHAUDHRY 6369 NORTH CHARLES STREET BALTI NORE

State Registrar

b

31. Date filed (Month, Day, Year)

MAY 2 2 2007



within 24 hours a

To the Funeral I

completely filled

Medical

				1 - For State Registrar	State	of Marylan		artment of rtificate o		d Mental Hy	giene	007	16520
		Dhusisi		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day	Year	3. Time of Death
_		Physici /Medi			HELEN FO					May 16	5, 200	7	8:30A M
U	k	Examir	ner	4a. Facility Name (If not institution	, give street and nu	ımber)		,	n, or Location of Do	eath		ounty of Death	
				STELLA MARIS  5. Social Security Number	6. Sex	7 800 (10.000	In a d b indb ato . 1	Tim	nonium ar   If Under 24 F	tre la Data d'Al			County
		Funeral Director		211-16-64/43 Usual Residence of Decedent	1□ M 2X F	7. Age (In yrs. 9)		Months Day		frs. 8. Date of Bi (Month, Da Oct 1	5, 191		olace (State or Foreign ntry) th Carolina
		72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Evanilrar must be notitled at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
		Mar Befst	to	Maryland Balti	nore Coun	itv	Ti	monium					1 ☐ Yes 2X No
Ø		or 28	by Funeral Director	10e. Street and Number				10f. Zip Code	9		10g. Citizer	n of What Cou	ntry?
P.		ath w	la l	2300 Dulaney V	alley Ro	ad			21093			USA	
30		er de Item	nue	11. Marital Status	Armed F		S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	0- 14.	Race - Ameri Black, White,	
00	36	rs aft	Jy F	1 ☐ Never Married 2 ☐ Marri 3 🂢 Widowed 4 ☐ Divorced	ed 1 ∐ Yes If Yes, G Year or I	2 X No ive		1□Yes 2XXIN	No Specify:		Sp	pecify: Wh	nite
	9	2 hou	be	15. Decedent		Jales.	16a. Dece	dent's Usual Occ	cupation		16h Kind	of Business/In	
	215	within 73 ene. then "na be Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed,	(1-4or 5+)	(Give life.	kind of work do DO NOT use ret	ne during most of ired)	working	, , , , , , , ,	3, 530, 1533, 11	, addity
	21	filed with Hygiene other the	ĕ	Clotheritaly/Odcoridary (0-12)		yrs	C1e	erk Typi	.st		Ke	lly Gir	:1
/	Maryland 21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "natural", or itema 23s or 28s-1 show adother the Medical Evarrier must be notified at	Be	17. Father's Name (First, Middle,					18. Mother's I	Name (First, Middle	, Maiden Su	ımame)	
2007	yla	2 should be and Mental I a marked o	2	Albert Ralph	Michton	n		_	Ida	Levy	7		
2	Jar	2 sh and in m		19a. Informant's Name/Relations		\$				Rural Route Numb			-
16,	e,	t end tealth am 27 thar tr		Albert R. Liebe	rman (	Son)				Luthervil			
2	altimore,	in of h		20a. Method of Disposition  1 XBurial 2 Cremation		State		sition (Name of natory or other p	1	Date	20c. Local	tion - City or Te	own, State
MAY		it. Partmer		4 Donation 5 Other (Sp 21. Signature of Emperal Service	pecify)	Be			dens 15/			Air, Ma	
	Ba	Deperiment of the periment of		100000	awson	n	Ň	ITTCHELL	-WIEDEFE	LD FUNERA	AL HOM	E, INC.	reservation to
				23a. Part1. Enter the disease, or shock, or heart failure. List		caused the death	n. Do not ent	er the mode of o	K ROAD, tving, such as care	Baltimore	Mar	yland 2	21212 Approximate
	30	Dhysisian	0.9	Immediate Cause (Final	only one cause on	each the.	_ m	4061	12/2/	10/21	2/100	~	Interval Between Onset and Death
♥	)_	Physician /Medical		disease or condition resulting in death)	a	(ors a copsequent	10000 of):					_	
		Examiner			0.00 10	12/2/	703	c/en	ofe	152r	1	112521	-
			ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	uence of):						
\	B	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
1	Ö,	e exe ien al urial-t	Ä	resulting in death) Last	Due to	(or as a consequ	uence of):						
	8760,	ate b hysic the bi	lical		d								
1	Box 6	Attanding Physician: The law requires thet the death certificate be executed in death.  actor: After this certificate has been signed by the eltending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE:	00. #								
1	Bo	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of pregna birth 2 Fetal	Ideath 3□	Ectopic pregnar			230	<ol> <li>Date of deliver</li> <li>Month</li> </ol>	ery Day Year
	о. О.	the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9☐Unkr	nant at time of do nown	eath 5∟	Other (specify)					
	۵.	w requires that the di been signed by the should be detached	H.	Part II. Dther significant condition	ns contributing to d	leath but not resi	ulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
FLORENCE	Records,	ures ld be	d by	Part II. Dther significant condition	127		,	, , , , , , , , , , , , , , , , , , , ,	•				pably 4 Onknown
OR	ဂ္ဂ	w req	lete	Corre	00 8/100	que	2/8	I de La		24a. Was	20 3	Ah Wasa auto	ppsy findings available
	æ	The la	Completed							auto perf	psy ormed?	prior to co death?	mpletion of cause of
>	ta	Iffical for, p	0	25. Was case referred to medical					26 Place of I	1 ☐ Yes Death (Check only		1 🗆 Yes	2 No
MA	$\geq$	ysici is cer direc	To B	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DOA C	0.1	g Home 5 ☐ Res		Other (Specia	50
FORTMAN,	Division of Vital	ng Ph ter th	L.	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date	of Injury oth, Day Year)	28b. Time of			28d. Describe			7/
F(	<u>ত</u>	andir sath. or: Af he fu	atle	2 Accident investig	ation	, ouy , ou,	injury		☐Yes 2☐No				
	ž	or Att ter de iracte iracte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Plac	e of Injury - Al ho	ome, farm, str	eet, factory, offic	08		(Street and N wn, State)	lumber or Rur	al Route Number,
		urs af	S										
		To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the teaminer: On the t	pasis of examina	wledge, death tion and/or in	n occurred at the vestigation, in m	time, date and pl y opinion, death o	ace, and due to the ccurred at the time,	cause(s) an	d manner as s ace, and due to	tated. o the cause(s)
		ithin ithe	Mec	29b. Signature and title of certifier	and mar	nner stated.			ense number	1		igned (Month,	
		F ≱ F 8		1000	koli	Mo			1550	54		17 · <	
	•	1.		30. Name and address of person	who completed cou	se of death /ltc=	23a) /Tune			-			
		H		EDDIE NAKHUD					ALLEY RO	AD TIMO	NIUM	MD 2	1093
		Sta		31. Date filed (Month, Day, Year)	32.1	Registrar's Signa	ture						
		Registr	rar	MAY 2 2 20	37 Lister	Registrar's Signa	A PORME	and the same of th					

**Physician** /Medical

Examiner

Director

Completed by Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

For State	0.000	•				ental Hygien	9	
Registrar			Certificate	e of Dea		Reg. No	2007	1 1552
. Decedent's Name (First, Middle,						Date of Death     Month Da		3. Time of Death
Wesley	Α.	Gentry		Tour	on of F	May 20	200	
a. Facility Name (If not institution,	give street and number	er)	4b. City,	Town, or Locati	,	40	c. County of Deat	ut
Sina: Hospital Social Security Number	of Baltim S. Sex 7.	Age (In yrs. last birth			der 24 Hrs.	8. Date of Birth		thplace (State or Foreigr
213-30-8909	1⊠M 2□F	74 Yr	Months	Days Hou		(Month, Day, Year	r) Co	aryland
Isual Residence of Decedent			ar l ca-a				,	
0a. State 10b. County		10c. City, Town			1			10d. Inside City Limits 1 ☐ Yes 2X No
	timore			ngs Mil	ls	10- 0	itizen of What Co	
0e. Street and Number 233 Gentle	Broot- D-	d	10f. Zip	Code 2111	7	Tug. C	U.S.A.	
	12. Was Decede	ent Ever in U.S.	13. Was Deced	dent of Hispanio	: Origin? (Spec	ify Yes or No-	14. Race - Ame	
<ol> <li>Marital Status</li> <li>         ∑Never Married 2 ☐ Marrie     </li> </ol>	Armed Force	es?	If Yes, spec	cify Cuban, Me	xican, Puerto F	Rican, etc.)	Black, Whit	
3 ☐ Widowed 4 ☐ Divorced	d 1 ☑ Yes 2[ If Yes, Give Year or Date	es:	1 ☐ Yes	2⊠ No Spe	ecify:		Specify:	White
15. Decedent's	Education	1 (	Decedent's Usua Give kind of wo	rk done durina	most of world		Kind of Business	/Industry
(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4e	``	life. DO NOT us	se retired)			D - •	
10			Pair	1	loth - 1	/Finn4 * 4" /	Paintir	ıg
7. Father's Name (First, Middle, L	·			18. N		(First, Middle, Maide	_	
Lonnie	A. Gen		Maille	(64	Mary		rker	Zin Codo
9a. Informant's Name/Relationshi	- •		_			I Route Number, City		
L. Anne Gentry	Sister	20b. Place of [	Disposition (Nar	me of		Apt 30 Ra	leigh, N	
0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		ate cemetery	r, crematory or o	other place)				
4 ☐ Donation 5 ☐ Other (Sp.	ecify)		aints Ce		5/22/		istersto	OTT IN STREET
1. Signature of Funeral Service L	-m Ge	nKins	ELINE I		HOME F	l824 Reist Reistersto		21136
23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cau	sed the death. Do no	ot enter the mod	de of dying, suc	ch as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
mmediate Cause (Final lisease or condition	a	Myocar	dial	infar	ction			5 Days
esulting in death)	Due to (or	as a con equence of	f):					
1	•							
Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):								
equentially list conditions, any, leading to immediate asse Front promiting	b. Due to (or	as a consequence of	f):					
nat initiated events	c							
nat initiated events	c	as a consequence of						
Sequentially list conditions, fany, leading to immediate care (Disease or injury that initiated events resulting in death) Last	c							
nat initiated events esulting in death) Last  F FEMALE:	c	as a consequence of	f):				23d. Date of de	elivery
F FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	as a consequence of as a consequence of the conseq					23d. Date of de Month	elivery Day Year
nat initiated events resulting in death) Last  F FEMALE: 23b. Was decedent pregnant	c	as a consequence of as a consequence of the conseq	f): 3⊟Ectopic p					*
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c	as a consequence of one pf pregnancy the 2 ☐ Fetal death and at time of death on	f): 3 ⊟Ectopic p 5 ⊟ Other (sµ	pecify)	Part I.	23e. Did tobacc	Month	*
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c	as a consequence of one pf pregnancy the 2 ☐ Fetal death and at time of death on	f): 3 ⊟Ectopic p 5 ⊟ Other (sµ	pecify)	Part I.		Month o use contribute	Day Year to the cause of death?
F FEMALE:  35. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c	as a consequence of one pf pregnancy the 2 ☐ Fetal death and at time of death on	f): 3 ⊟Ectopic p 5 ⊟ Other (sµ	pecify)	Part I.	1 <b>Y</b> es 24a. Was an	Month  o use contribute to the contribute of the	Day Year to the cause of death? Probably 4 □Unknow
FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c	as a consequence of one pf pregnancy the 2 ☐ Fetal death and at time of death on	f): 3 ⊟Ectopic p 5 ⊟ Other (sµ	pecify)	Part I.	1 ₹Yes	Month  o use contribute to the	Day Year  to the cause of death?  Probably 4 □Unknow  autopsy findings available completion of cause of
FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  art II. Other significant condition  Congressive 5.	c	as a consequence of one pf pregnancy the 2 ☐ Fetal death and at time of death on	f): 3 ⊟Ectopic p 5 ⊟ Other (sµ	cause given in F		1 Yes  24a. Was an autopsy performed:	Month  o use contribute to the	Day Year  to the cause of death?  Probably 4 □Unknow  autopsy findings available completion of cause of
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c	as a consequence of one pf pregnancy the 2 ☐ Fetal death and at time of death on	f):  3 □Ectopic p 5 □ Other (sy	cause given in F	Place of Death	1  Yes  24a. Was an autopsy performed 1  Yes 2  1	Month  o use contribute ( 2 No 3 F  24b. Were a prior to death? No 1 Ye	Day Year  to the cause of death?  Probably 4 □Unknow  autopsy findings available completion of cause of
FFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant condition  Hypertension  Congestive L  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manper of Death	C	as a consequence of the pregnancy of the 2 Fetal death of the pregnancy of the sequence of the pregnancy of	f):  3   Ectopic p 5   Other (sy the underlying o	cause given in F  26. CA Other: 4 28c. Injury at Work?	Place of Death ☐ Nursing Hor	1 1 Yes  24a. Was an autopsy performed; 1□ Yes 2 1 Check onlone	Month  o use contribute ( 2 No 3 F  24b. Were a prior to death? 1 Ye  6 Other (Sp	Day Year  to the cause of death?  Probably 4 □Unknow  autopsy findings available completion of cause of
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown 2art II. Other significant condition  Hypertension  Congrestive    25. Was case referred to medical examiner? 1   Yes 2   No    27. Manper of Death   12   Natural   5   Pending investig	C	ome pf pregnancy th 2 Fetal death that at time of death th but not resulting in  patient 2 ER/Out Injury Day Year)  28b. T	all Ectopic p begin{align*} 3   Ectopic p begin{align*} 5   Other (sp begin{align*} the underlying c begin{align*} patient 3   DC begin{align*} DC begin{align*} mathematical color begin{align*} mathemathematical color begin{align*} mathematical color begin{align*}	26. CA Other: 4 28c. Injury at Work? 1 \  Yes	Place of Death  Nursing Hot	1 ☑ Yes  24a. Was an autopsy performed; 1 ☐ Yes 2 ☑ In Check only one me 5 ☐ Residence 28d. Describe how in	Month  o use contribute to the contribute of the	Day Year  to the cause of death?  Probably 4 □Unknow  autopsy findings availably completion of cause of  s 2 ☑ No
FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  art II. Other significant condition  Lypertension  Congrestive 1  5. Was case referred to medical examiner?  1 Yes 2 No  7. Manper of Death  1 Natural 5 Pending	C	as a consequence of the pregnancy of the 2 Fetal death of the pregnancy of the sequence of the pregnancy of	all Ectopic p begin{align*} 3   Ectopic p begin{align*} 5   Other (sp begin{align*} the underlying c begin{align*} patient 3   DC begin{align*} DC begin{align*} mathematical color begin{align*} mathemathematical color begin{align*} mathematical color begin{align*}	26. CA Other: 4 28c. Injury at Work? 1 \  Yes	Place of Death  Nursing Hot	1 ☑ Yes  24a. Was an autopsy performed; 1 ☐ Yes 2 ☑ In Check only one  me 5 ☐ Residence 28d. Describe how in	Month  o use contribute to a second to the contribute to the contr	Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available completion of cause of

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Be Completed by Medical Certification: To

25. Was case re-examiner? 1 ☐ Yes 2 27. Manner of De 2 Acciden 3 ☐ Suicide 4 ☐ Homicid 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

RES-000

May

20

2007

Va

DHMH 17 Rev 1/2001

State

Registrar

Hao Irene 31. Date filed (Month, Day, Year) MAY 2 2 2007

29b. Signature and title of certifier



e How

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sina: Hospital of Baltimore

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Gerard Girlando, Sr. X:35 PM MAY 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ST AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/21/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 □ F 219-16-2962 81 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 719 Maiden Choice Lane HR206 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Girlando Sarah Glorioso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) M. Madeline Girlando (Wife) 719 Maiden Choice Lane HR206, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral 05/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Mark T.

Physician /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

<u>م</u>

Completed

Be

Be Completed

Physician/Medical Examiner burial-trar the cate has been signed! page 2 should be det Medical Certification: To filled in by

Division or Vital Records, P.O. Box 68760,

JOSEPH

FIRLANDO

within 24 hours at To the Funeral Completely filled it State Registrar

or Attending

Hospital

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE:

23a. Part1. Enter the disease shock, or heart failure.

Due to (or as a consequence of Coronary Due to (or as a consequence of) Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

Acute

3 Ectopic pregnancy 5 Other (specify)

or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest is tarily one cause on each line.

Myocardial Infarction

Artery Disease

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Tes 2 No 3 Probably 4 Unknown

Year

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

and manner stated.

Chronic Kidney Disease

24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Matural

3 ☐ Suicide

29a. Certifier

5 Pending investigation 2 Accident 6 ☐ Could not be 4 Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 29b. Signature and title of certifier

29c. License number P 20657 29d. Date signed (Month, Day, Year) 2007

ALDANDASHI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

900 Caton Ave, Baltimore, MD Mahmoud Aldandashi.

2 ER/Outpatient 3 DOA

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma		epartment of Certificate of			giene 200	7 16523
			Decedent's Name (First, Middle, L.)	ast)			200	2. Date of Dea	ith	3. Time of Death
	Physici		T SMAFI /	2NNTALF	7			Month	Day Year	7 8.20PM
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town,	or Location of Dea		4c. County of Dea	0,20
		٠.	ENREST HAVE	N NURSIN	G HAN	1+ CATI	NSVILL	E	BALTIN	10RE
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	day) If Under 1 Yea Months Day:			y Year) 9. Bir	rthplace (State or Foreign ountry)
	Director		581-34-7946	1XM 2□F	76 <sup>Y</sup>	s. Worting Day	5 Hours will	12/30/		erto Rico
	pu &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	eho eho	'n	Maryland Carrol	_	Taney					1 ☐ Yes 2 ₩No
	28e-f	Director	10e. Street and Number		Taries				10a Ciriman of Minas C	
	with	급				10f. Zip Code			10g. Citizen of What C	ountry ?
	s 23	eral	157 Bentley Str	eet 12. Was Decedent E	ver in LLS	2178		(Specify Ves or No-	United Sta	
	iter d	Ľ	1 □ Never Married 2 □ Married	Armed Forces?		<ol> <li>Was Decedent of If Yes, specify Cu</li> </ol>	iban, Mexican, Pue	erto Rican, etc.)	Black, Whi	
8	urs at	by Funeral	3 ⊠Widowed 4 □ Divorced	If Yes, Give		1 Yes 2□ N	o Specify:	erto Rica	Specify:	Hispanic
Ģ	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f ehow the Medical Exemiter mant be multified at	Completed	15. Decedent's	Education	950-54 16a. 0	ecedent's Usual Occ	upation		16b. Kind of Business	
2	Pin 7	ple	(Specify only highest g	rade completed) College (1-4or 5+		Give kind of work don ife. DO NOT use retii	e during most of w red)	rorking		
7	or the	Con	9		<u> </u>	Bartende	er		Hospita	ality
2	al Hy d oth	Be (	17. Father's Name (First, Middle, Las	_				am <i>e (First, Middle,</i>	Maiden Sumame)	-
Maryland 21215-0036	Ments Ments arked	To	Juan Gon	zalez				Incarnaci	on Lorenzo	
a L	and le mu	i i	19a. Informant's Name/Relationship		19b. I	Mailing Address (Street	et and Number or F	Rural Route Numbe	r, City or Town, State,	Zip Code)
≥.	and ealth n 27	0	Mrs. Francisca P	agan		3 Dogwood	Road E	Baltimore,	, MD 21207	7
ore	of H of H if Iter		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3	□Removal from State	cemetery,	isposition (Name of crematory or other pi	, ,	Date	20c. Location - City or	
Ĕ.	Pages ment of I ant: If It ury or o		4 Donation 5 Other (Spec		Arbutu	s Memorial	Pk. 05/	25/2007	Baltimore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depermit of Health and Mental Hygiene in Emportance of Health and Mental Hygiene Traduct, or items 23a or 28e-f ehow any lighty or other treumatic event, the Medical Exeminal mental re-neithed at once.		21. Signature of Funeral Service Lic	ensee		22. Name and Add	1.		uneral Home Lmore, MD 2	
			23a. Part1. Enter the disease, or shock, or heart failure. List on	mplications that caused t	he death. Do no					Approximate Interval Between
a	Physician	. 4	Immediate Cause (Final			Carchiovas	A			Onset and Death
	/Medical		disease or condition resulting in death)	a. A Hurosch	consequence of		SCIENCY 12	126002 C		
	Examiner									
1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of	:				
	cuted	Examiner	that initiated events	c.						l l
o	be executed sicien and burial-transit	Ë	resulting in death) Last	Due to (or as a	consequence of	:			1),	
8760,	2 2 2	dlcal		d						
<u> </u>	leath certifica attending ph I for use as t	Med	IF FEMALE:							
Вох	ith ce tendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2		3 □Ectopic pregnan	су		23d. Date of de	
E	e dea he at	sici	1 Yes 2 No	4☐ Pregnant at ti 9☐ Unknown	me of death	5 ☐ Other (specify)			Month	Day Year
P.O.	thet the de led by the a detached t	Phy						on- Dida		
Ś	res the signed be det	۵	Part II. Other significant conditions	contributing to death but	not resulting in t	ne underlying cause g	jiven in Part I.		bacco use contribute t	
5	w require	Completed							es 2. III No 3 □ P	robably 4 Unknown
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<u>~</u>	: The	ဝ						perfor 1 ☐ Yes	med death? 2 ☐ No 1 ☐ Yes	5 2 □ No
Division of Vital Records,	or Attending Physicien: The after death. Director: After this certificate he in by the funeral director, page	Be	25. Was case referred to medical examiner?	Magnital				eath (Check only or		
<b>o</b>	Phys this al dir	2	1 ☐ Yes 2 ☑ No	Hospital:		atient 3 DOA	4 Nursing		ence 6 Other (Spe	ecify)
5	Jing I	Certification;	27. Manner of Death  ↑ ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir Inj	ary W	uryat ork? ⊒Yes 2.⊒No	280. Describe n	ow injury occurred	
<u>s</u>	deatl deatl stor: / the	ca	2 Accident investigati 3 Suicide 6 Could not	be 200 Plans of laive	At home fore	n, street, factory, office		29f Location (S	treet and Number or R	humi Davia Mumbar
<u> </u>	after deat Director: I in by the	ert	4 ☐ Homicide determine	building, etc.	(Specify)	i, street, factory, office	•	City or Tow		urai nobie womber,
_	Hospital or Al 24 hours after of Funeral Directory filled in by		29a. Certifier 1 10 Certifying F	hysician: To the best of	mu knowled ie	feath occurred at the	times, date and nine	no and due to the e	aus s/s) and manner a	E statud
	P Hor	edical	(Check only 2 Medical Exa	miner: On the basis of e	xamination and/	or investigation, in my	opinion, death occ	curred at the time, o	late and place, and du	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of sequitor	0		29c. Licer	nse number		29d. Date signed (Mon	th, Day, Year)
0	1 1		DeroV.	& Seen	Com	200	FEEEE2	_	5-18-0	7
2	1		30. Name and address of person who	completed cause of dea	ath (Item 23a) (T	1		1		
4		1	Dorothy Seay	, MD 253	35 Sm	ith Ave	Balt	more, Ma	1 21209	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	ask s				
3	Registr	ar	MAY 2 2 20	UI MARCHANTER	15 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BONNIE AGARD GEHRING <u>10:0</u>0 ₽<sup>M</sup> May 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County GILCHRIST CENTER Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month Day, Apr 16, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 😾 F 66 025-32-1527 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Baltimore County Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 21212 USA Funeral 6904 Wardman Road within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐ Yes 2 No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21☑ No Specify. Specify: White à 3 Widowed 4 Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Co. 12 should be filed within h and Mental Hygiene. 7 is marked other than than Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Physical Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving H. Agard, Jr. Mildred 4 1 2 2 2 2 2 2 Dowling Dowling ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 is I 6904 Wardman Road, Baltimore, Maryland 21212

Date 20c. Location - City or Town, State (Husband) Mr. William L. Gehring 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 5/22/2007 Baltimore, Maryland 21. Sign We of F-mal Server Nicesee

Martin D. Dawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER **Physician** An sean disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the a 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has 1 2 1 No Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Injury 1 Natural investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

Date filed (Month, Day,

Year)

2

2007

State Registrar

ny

address of parson who completed cause of death Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			For State State Registrar	ate of Maryland		nent of H cate of I		lental Hy	rgiene. U	U/	10070
			Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death
	Physici		Rita Franc	as Guy				Month	Day 15	Zcc7	12:20 AM
1	/Medio Examin		4a. Fecility Name (If not institution, give street		4b.	City, Town, or	Location of Death	ricy		ty of Death	7-0-0
	LAdillii	CI	Johns Hookins Care	Center		Balt	more		Balt	Imore	City
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi		9. Birthp	lace (State or Foreign
	Director		212-30-8419 1 I M 2	72	Yrs.	nuis Days	Hours Min.	8. Date of Bi (Month, Di NOV •	1934	Mar	yland
	pu »		Usual Residence of Decedent  10a. State 10b. County	100 City	, Town or Location					1	0d. Inside City Limits
	sho	5	Maryland N/A	100. Ony	, rown or Location						1x Yes 2 □ No
	he M	Director	10e. Street and Number			V 7 0 1	Balt	imore (	ity 10g. Citizen o	( )A/bat Caus	
	with 1					of. Zip Code	1004				
	eath	eral	3324 Fleet Street  11. Marital Status 12. W	as Decedent Ever in U.S	S 13 Was I		L224	ecity Yes or N	United	State	
	72 hours after death with the Maryland naturel', or Items 23e or 28a-f show Jigal Examiraer suct be notified at	Funeral	Ar	med Forces? □Yes 2[2]No	If Yes	, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)	BI	ack, White,	
336	urs al	by	- Committee of the second seco	Yes, Give ear or Dates:	1 🗆 Y	es 21K No	Specify:		Spec	ify: W	hite
Õ	72 hours "naturel",	Completed	15. Decedent's Education	=(a4a=f)	16a. Decedent's	Usual Occup	ation	·	16b. Kind of	Business/In	dustry
215	- "	pie	(Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. DO N	OT use retired	during most of work f)	ing			
2	filed will Hygien ther th	Son	10 Years		Clerk						e City
pu	be filed withii ital Hygiene. Id other then event, Ite M	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	- ,,		ıme)	
yla	should be filed withir nd Mental Hygisne. markad other then imatic event, II.e M.	၉	James Stanley Polor						niewski		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type, Pi		_		and Number or Rur		-		
ر ا	s 1 and 2 should f Health and Men Item 27 is marka other treumatic			ghter)	3328 .	Fleet S			e, Mary		21224
O	ges 1 t of H ff Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	al from State	emetery, cremator	y or other plac	:0)	Date	20c. Location		
ţ	tmen tant; jury		' 4 □ Donation 5 □ Other (Specify)	Sa			sus Cem.				Maryland
Baltimore,	permit. Pages 1 and Department of Healt Important; if Item 2 any Injury or other once.		21. Signature of Funeral Service Licensee	lan	22. Nar Du	ne and Addres da-Rucl 22 Wise	ss of Facility	Home o	f Dunda Maryla	alk, I and 21	nc. 222
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pulmonary	Gual al	e and					Onset and Death
-	/Medical		resulting in death)	Due to (or as a cons-		>					1000
	Examiner		Sequentially list conditions	Deep Venou	15 Thron	m bosis					Days
	ъ =	ner	cause. Enter Underlying	Due to (of as a consequ	10 III (#1985)						
	ecute and trans	Examiner	Cause (Diseese or injury that initiated events c. resulting in death) Last	Hypercoo	rgulable	State					Days
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9 ×			IF FEMALE: 23c If	yes, outcome of pregnar	ncv				024 0	hate of dollar	
Вох	atte	Physician/M	in the past 12 months?	□Live birth 2 □ Fetal □Pregnant at time of de	death 3 Ecto	pic pregnancy er (specify)			1	ate of delive fonth	Day Year
P.O.	that the de ed by the detached	isic		Unknown	3.00	or (specify)					
۵	es that thighed by be detact	Ph/	Part II. Other significant conditions contribut	ing to death but not resu	Ilting in the underly	ying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
ds.	uires n sign Ild be	d by	Emphysema		Atrial	Fibrilla	Hon	1 🗆	Yes 2□No	3 (Prob	ably 4 DUnknown
00	w require been significations	Completed	Market Obest.			•		24a. Wa:	an 24b	. Were auto	psy findings available
Re	The law ete has page 2 :	m	CI CI	1				auto	ormed? 2 No	prior to con death?	mpletion of cause of
la	icien: Th certificete rector, pag		Obstructive Sleep & 25. Was case referred to medical	tonea	<del></del>		26. Place of Deatl			1 🗆 Yes	2 No
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Division of Vital Records,	는 는 E	L	27. Manner of Death 28	a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun			how injury occu		,,
io	ndin ath. r: Aft e fun	atio	1 Natural 5 Pending 2 Accident investigation	(MOHII, Day 19ar)	Injury N		Yes 2□No				
Vis	Atte ar de ecto by th	ific	3 Suicide 6 Could not be determined 28	e. Place of Injury - At ho building, etc. (Specify	me, farm, street, f	actory, office		28f. Location	(Street and Nun wn, State)	nber or Rura	I Route Number,
Ō	s afte	Certification:	4 Tromode	building, atc. (Spaciny	7			Oily of 70	wn, state)		
)	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	cai	29a. Certifier 1 Certifying Physicien (Check only 2 Medical Examiner: C	To the best of my know	wledge, death occ	urred at the tin	ne, date and place,	and due to the	cause(s) and r	nanner as s	tated.
	the H hin 24 the F mplete	Medicai	one) a	nd manner stated.	ion and or mvestig			ed at the time			
	To To Corr	2	29b. Signature and title of certifier			29c. License	e number		29d. Date sign		
	1		1846 Seem	e MD		D7	+479		May	15	,2007
1	, Y		30. Name and address of person who complete		23a) (Type, Print	12	. 4. 1	- 1	> 1	,	, 2007 10 21224
¥			Brock Beame	5505	Hopkins	. Day V	iew Circl	e	20/Amo	re, N	D 21224
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Year **Physician** 9:10 P M MAY 18 2007 JOSEPH ERNEST GRAY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH AND REHABILITATION FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Maryland 7, 1921 Director 215-18-7304 86 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the M-dical Examiner must be notified at 1 X Yes 2 No Bel Air Maryland Director Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21014 USA 209 Thomas Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be flied withir. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mae S. Stuard Joseph Ernest Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 Holly Neck Road, Essex, Maryland 21221 of Disposition (Name of Date 20c. Location - City or Town, Sta Linda A. Gray / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 5-23-07 Bel Air, Maryland Funeral Service Monsee 22. Name and Address of Facility.
McComas Funeral Home, P.A. 21. Signature 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) chronic als /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the 88 IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🧗 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1□ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ျှ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Injury Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1000 S may 19, 2007 D32295 44 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD DR. DAVID DUNN BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 2 2 2007

		1 - For State Registrar	State of Ma	ryland /	Department of F Certificate of I		ental Hygier Reg. N	Z [ ] [ ]	15527	
Physic /Medi		1. Decedent's Name (First, Middle, Last)  MILDRED T. GREGORY					2. Date of Death Month MAY 18	<sup>Day</sup> 2007 Year	3. Time of Death 10:50A. M	
Exami Funeral	ner	4a. Facility Name (If not institution, given HOSPICE OF BALTI  5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 7. Security Number	MORE GILCHE	RIST CE	NTER TO	WSON  If Under 24 Hrs. Hours Min.	8. Date of Birth	BALTI  9. Birth		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marhal Hygiene. Important: If item 27 is marked other than "intural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent		10c. City, Tow	vn or Location	ERVILLE	12-16-192	24   M	10d. Inside City Limits 1 □ Yes XXXNo	
	Funeral Director	10e. Street and Number 17 GORSUCH ROA			10f. Zip Code	093	10g. (	Citizen of What Co		
USO ours after deal al", or items : Examiner mu	by	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X VN If Yes, Give Year or Dates:	ver in U.S. o	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes (XX) No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:		
d within 72 ho d within 72 ho giene. In than "natur the Medical.	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12 YEARS	ducation ade completed) College (1-4or 5-	<u>.                                      </u>	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired SCHOOL SECR	durina most of workir	DEF		EDUCATION COUNTY	
VIZITIO , unid be filed Mental Hygarked otheratic event,	To Be C	17. Father's Name ( <i>First, Middle, Last</i>	) RNARD BLAN	т иоти	AYLOR	18. Mother's Name	(First, Middle, Maid RYN TEMPE		ULLER	
and 2 sho ealth and I m 27 is me			Type. Print) RY , JR . (HUSE	BAND) 1	b. Mailing Address (Street 7 GORSUCH RO	AD, LUTHE	RVILLE, MA	ARYLAND,	21093	
DallIMOTE  ermit. Pages 1  bepartment of H  mportant: If ite iny injury or ott		20a. Method of Disposition    XX Burial 2								
Deparit Depar Impor any in	65	21. Signature of Funeral Service Lice	(R. G. RUT		22. Name and Addre	N FUNERAL		1050 Y TOWSON	,MD.21204	
Physician /Medical Examiner	Medical resulting in death)  Due to (or as a prequence of):								Approximate Interval Between Onset and Death	
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):								
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal deat	h 3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of deli Month	ivery Day Year	
w requires that been signed be should be deta	by	Part II. Other significant conditions	contributing to death bu	t not resulting	in the underlying cause giv	en in Part I.			the cause of death?	
ar neco	Completed						24a. Was an autopsy performed' 1□ Yes 2	prior to o death?	topsy findings available completion of cause of 2 ☐ No	
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending investigatio 3  Suicide 6  Could not be determined	e 290 Place of inju	y 28b.	Time of lnjury 28c. Injur	y at k? Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ne 5 ☐ Residence 28d. Describe how in 28f. Location (Street City or Town, St	njury occurred  and Number or Ru		
Hospital or Hospital or A hours aft Funeral Di		(Check only 2 Medical Exa	nysician: To the best o	of my knowledge examination a	ge, death occurred at the ti and/or investigation, in my o		and due to the cause	e(s) and manner as		
To the P within 24 To the F complete	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and durand manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mon.)  18d. April 18d.						Date signed (Month	h, Day, Year)	
10		30. Name and address of person who	BE 100 1	1711	Al Claude	o St TU	WSUN M	0 21201	4	
St Regist	ate trar	31. Date filed (Month, Day, Year)  MAY 2 2 2	32 Hegistra	i s Signature	Aparle .					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Physician Isabella Moncreiffe May 19, Grier 2007 9:02 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Fallston 2011 Copperwood Way Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 22, 1914 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 □ M 2 X F Yrs. Maryland 93 Director 212-05-1550 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Director **Fallston** Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 2 must be n U.S.A. 2011 Copperwood Way 21047 Funeral 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. th and Mental Hygiene.
7 Is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 【X No Specify: Specify: <u>م</u> 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Operator 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gourlay Margaret ဥ John Zink 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau 2011 Copperwood Way Fallston, Maryland 21047 Marshall V. Grier 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Sherwood Episcopal Church Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5-23-2007 Cockeysville, Maryland 21. Signature in Filter | Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** netoutan /Medical Due to or as a consequence of): **Examiner** Canct 1 una Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9∐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deaft

To the Funeral Director

completely filled i by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mv address of person who completed cause of death (Item 23a) (Type, Print) 5 Chail Ad 615 nechni Registrar's Sign

Registrar DHMH 17 Rev 1/2001

State

			For State Registrar	State of Maryland	I / Department Certificate		ntal Hygiene Reg. No.	.001 10020	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Human			2. Date of Death Month Day	Yeer 3. Time of Death A 4,00 M	
	Examin Funeral	14	4a. Facility Name (If not institution, give s. 3717 Oakmor 5. Social Security Number 6. Sex	treet and Number)  The Augusta Tr. Age (In yrs. Ia	Bast birthday) If Under 1	Own, or Location of Death  Third Pe Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)		
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location		1MQ1 41 15,1	10d. Inside City Limits	
	the Mary	Director	Md, MA	Ba	altimor 101. Zip		10g. Citi	1 💆 Ŷes 2 🗆 No izen of What Country?	
	death with ms 23a or rmust be	Funeral Di	3717 Oakmon	2. Was Decedent Ever in U.S Armed Forces?	3. 13. Was Decede	1215 Int of Hispanic Origin? (Sty Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	
900	hours after death with the Maryland turel; or Items 23a or 28a-f show al Exentrer must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify: Black	
21215-0036	within 72 ane. than "na	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)  College (1-4or 5+)	16a. Decedent's Usual (Give kind of work life. DO NOT use	done during most of wor.	king 166. K	alta. Citu	
Maryland 2	should be filed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Francis W.	Carroll		18. Mother's Nan	ne (First, Middle, Maiden	Sumame)	
-	is 1 and 2 should of Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Tyx)  MS, Elvera V  20a. Method of Disposition	Villiams	3 // / UC ace of Disposition (Name	Kmont.	Ave. Bal	or Town, State, Zip Code)  12, M.J., 21215  ocation - City or Town, State	
Baltimore	permit. Pages Department of I Important: If it eny injury or o		1 A Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	amoval from State Ma	rmetery, crematory or off	honal 5/25	12007 La	urel, Md.	
Ba	Degrament of the control of the cont		23a. Part / Enter the disease, or complishock, or heart failure. List only on	Kuss	Joseph 2222 V	LI, RUSS FU NOTTH AVE	ineral Hon Balto. N	Approximate	
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Small  Due to (or as a consequ	Cell L	UNG CA	NCER	Interval Between Onset and Death	
	Examiner	ner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianga offi				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
9	leath certificate attending physi I for use as the	P	IF FEMALE:	3c. If yes, outcome of pregnar	nev			23d. Date of delivery	
P.O. Box	it the death of by the attent tached for us	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pre			Month Day Year	
	quires that the signed by all be detacted	by	Part II. Other significant conditions con	tributing to death but not resu	Iting in the underlying ca	use given in Part I.		use contribute to the cause of death?	
Il Records,		Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No	
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 🗌 Inpatient 2 🗍 I	ER/Outpatient 3 □ DO	Other	ath (Check only one)	6 □Other (Specify)	
on of	After After		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury 48or?  28a. Date of Injury 28b. Time of Injury Work?  M 1 Yes 2 No			28d. Describe how injury occurred		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)				
	Hospit 24 hour Funera etely fills	Medical (		sician: To the best of my knowner: On the basis of examinat and manner stated.				s) and manner as stated. Id place, and due to the cause(s)	
	To the To the compl	Me	29b. Signature and itle of certifier	2 UD		License number		ate signed (Month, Day, Year)	
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	16237	5/4	21/2007 D 21229	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa		WE BALL	IMORE M	D 21227	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 20, 2007 5:30 A M Pauline Mayola Horn 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Baltimore 3007 Sixth Avenue 8. Date of Birth June 23, 1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours MaryTand 1 ☐ M 2 🛣 F 78 217-24-9654 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Baltimore 1 ∐Yes 2 XNo Baltimore MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 3007 Sixth Avenue Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZANo If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) The Park School College (1-4or 5+) Elementary/Secondary (0-12) Bookeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Maude Haines John W. Royston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3007 Sixth Avenue-Baltimore, Maryland 21234 Dawn Wiland-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cenetery May 23, 2007 Rossville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville, Maryland 21234 andrae AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Aset and Death Immediate Cause (Final disease or condition resulting in death) Breast YEATS. Tue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ■ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? /es 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

as the burial-trans and jo filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

ms 23a or 2 must be n

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical δ Completed Be

attending physician this death hours after death uneral Director: within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year) 21107

ed cause of death (Item 23a) (Type, Prior)
MAN. F106 Wh. Adelphia Cont); MAN. 30. Name and address of person y 31. Date filed (Month, Day, Year)

State Registrar

completely

MAY 2 2 2007



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Wallace Anton Hopkins, Jr

		- For State	Mai yiana / L	Certifica					eg. No.	107 1453
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Wallace Anton Ho	opkins Jr.					2. Date of Deat Month May 19, 20		3. Time of Death 1238 hrs
		Facility Name (if not institution, give street and number)     307 Northfield Place			4	o. City, Town, or Baltimore	Location of [	Death	4c. County of Death n/a	
Funeral		5. Social Security Number 6. Sex	7. Age (ir	yrs. last birt	hday)	If Under 1 Yea		24Hrs. 8. Date of Birt		Birthplace (State or reign
Director			2F	62	Yrs.	Months Day	S Hours	Nov. 8	3,1944	Country) Maryland
any		Usual Residence of Decedent  10a. State 10b. County		c. City, Town		n				10d. Inside City Limits
land f show	اق	Maryland n/a		Baltin	nore					1XX Yes 2 No
th the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number 307 Northfield Pl	ace			10f. Zip Code 2121	0	11	0g. Citizen of What 0	Country?
with th		11. Marital Status	2. Was Decedent Eve	er in U.S.		Decedent of His	spanic Origin	? ( Specify Yes or No-	14. Race - Ar	merican Indian, Black,
r death or iter	Funeral	1 Never Married 2 Married 3 Widowed 4 XXDivorced If	Armed Forces? Yes 2XX	No		s, specify Cubar Yes XX No		Puerto Rican, etc.)	White, et	
ours afte	황	3 Widowed 4 XXDivorced If a 15. Decedent's Education (Specify only	Dates:		Decedent'	s Usual Dccupa	tion (Give kin		Specify: 16b. Kind of Busine	White ess/Industry
n 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			st of working life	e. DO NOT us	se retired)	D 1.	
215-0036 be filed within 77 ntal Hygiene. rked other than ent, the Medical	틹	17. Father's Name (First, Middle, Last)	4		Con	sultant	18.Mother's	Name (First, Middle, M	Banking Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than the veent, the Medica	B B	Wallace Anton Ho						ienne		riz
MD 2 ed 2 should lith and M m 27 is m anmatic		19a. Informant's Name/Relationship (Type Louisa Schaefer (Da						er or Rural Route Num Baltimore,		
re, N s I and of Health If item	Ì	20a. Method of Disposition  1 Burial 2 XXCremation 3	Removal from State	20b. Place		ion (Name of ce		Date	20c. Location - City	
Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 Other Specify:		Green		Cremator		5-22-07	Baltimore,	
Bal permit Depar Impo		27. Signature of Funeral Servic Lice	1		22. Na			fitchell-Wied ad Baltimore		
Physician		23a. Part I. Enter the disease, or complic failure. List only one cause on each		death. Do no	ot enter the					Approximate Interval Between Onset and
Examiner	cate be executed by Section 1 Pages I and 2 should by Section and be burial - transit burial - transit burial - transit Total Examiner To Medical Examiner		herosclerotic Ca e to (or as a conseque		ase				Death	
( )		Sequentially list conditions.								
	mine	cause. Enter Underlying Cause	e to (or as a conseque							
ansit ansit		events resulting in death) Last Du	e to (or as a consequ	ence of):						
be exec	dica		AMENDED							
8760 ifficate ong phys		123h Mas decedent pregnant in the								ivery Day Year
Sox 687 leath certifing e attending for use as t	sician	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time	0.06		er (Specify)	-			
that the done bed by the detached i		Part II. Other significant conditions		ıt not resultin	g in the ur	iderlying cause	given in Part	I. 23e. Did to	bbacco use contribute	e to the cause of death?
S, P. uires th n signed ld be de	ed by							- 4.000		Probably 4 🗹 Unknown
cords, law requir has been s	Completed							24a. Was autop		e autopsy findings available to completion of cause of h?
tal Recinan: The certificate ector, page	ဦ	25. Was case referred to medical				26.Place	e of Death (C	1 Yes	2 V N 1	Yes 2 No
Vita hysicia this cer	a Be		pital: 1 Inpatient	2 ER/O	utpatient		Other:		Residence 6 🗸 0	ther: Scene
n of hiding Ph.		27. Manner of Death  1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b.	Time of In		ıry at Work? Yes 2 N		now injury occurred	
Division pital or Attent ours after death neral Director: filled in by the	ficati	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home, fa	arm, street			28f. Location (S		r Rural Route Number, City
Div Spital o	Certification:	4 Homicide determined	(Specify)					or Town, S	itate)	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner:O	n the basis of examina							
To Nij	ğ	29b. Signature and title of certifier	nd manner stated.			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		West 2	_			O.C.	M.E.		Mayo	21,2007
15		<ol> <li>Name and address of person who cor Assistant Medical Examin</li> </ol>			ıltimpre.	MD 21201			1	,
Sta		31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	Local	\$ JA				
Registr DHMH 17 Rev 1/200	_	MAY 2 2 2007	100000	OR	IGINAL	L. P.			<del> </del>	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:00 A. May 21, 2007 FRANCIS LEONARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) N/ABaltimore 120 E. Lake Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Days 1**X** M 2□ F 75 Director <u>143-24-2611</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 X Yes 2 ☐ No Baltimore Director N/AMaryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 U.S.A. 120 E. Lake Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X) Yes 2 □ No If Yes, Give Year or Dates: 1950–52 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Extiminer once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Environmental Engineer 5+ years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schilling Regina ပ John Francis Hunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland (wife) 120 E. Lake Avenue Lois A. Hunt 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5-23-07 Baltimore, Maryland Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 was 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) diac minutes Physician /Medical Due to (or as a consequence of): **Examiner** perten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68766, Cy and Due to or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) I□Yes 2□No 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral ( 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Matural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 York Rd, Suite 224; Towson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** DONALD NELSON HARRIS MAY 20, 5:55 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6-16-1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1XM 2□F MARYLAND 82Yrs Director 220-18-9387 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" -- " any injury or other traumatic events." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No PARKVILLE BALTIMORE **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9002 WAETHERVANE GARTH 21234 U.S.A. 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Forces, My Yes 2 No if Yes, Give Year or Dates 1945-46 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AUTO SALES AERO MOTORS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN BOND HARRIS ELIZABETH JANE (ELMOS) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type. Print) 9002 WEATHERVANE GARTH PARKVILLE, JEANINE MAJEWSKI/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, 5-23-07 MARYLAND OAKLAWN CEMETERY 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME e of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause for the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \mathbf{X}$ Other (Specify) **HOSPICE** 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA

DONALD HARRIS

2007

Division or Vital To the Hospital or Attending Physician: this n 24 hours after death.

ne Funeral Director: A

bletely filled in by the fi

Certification: To

29a. Certifier

(Check only one)

Medical

State

Registrar

completely

within 24

27. Manner of Death 1 ▼ Natural 2 ☐ Accident 3 Suicide 4 ☐ Homicide

29b. Signature and title of certifier

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM, MD 21093

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD 2300 DULANEY YALLEY RD.

31. Date filed (Month, Day, Year) MAY 2 2 2007 32. Registrar's Signature

			1 - For State Registrar	State of Maryland	-	tment of I ificate of			ene 007	16534
Ī	Physici /Medi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Examir Funeral	ner	5. Social Security Number 6. Sex	ny Home	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	Lun 8. Date of Birth	4c. County of Death  Pulm (I)  Year)  9. Birthpt County	ace (State or Foreign
Director Moyou		or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 1							od. Inside City Limits
1215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hyglene. ortant: If Itam 27 is marked other then "natural, or Itame 23a or 28a-f ehow injury or other traumatic event, Ita Madical Examination Italian at injury or other traumatic event, Ita Madical Examination Italian at a.e.	Completed by Funeral Director	10e. Street and Number  11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  15. Decedent's Educy only highest grade  Elementary/Secondary (0-12)	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	13. Wall 1 Land	as Decedent of Yes, specify Cut	Specify: pation during most of wo	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify Black 6b. Kind of Business/Ind	an Indian, atc.
re, maryland	s 1 and 2 should be filed Health and Mental Hyg tam 27 is marked other other traumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Sendy hingsbury  19a. Informant's Name/Relationship (Ty,  Laverne D. hings  20a. Method of Disposition	SburyWiece 20b. Place	19b. Mailing	Address (Stree	Maril and Number or Al	me (First, Middle, M In Marina Ural Route Number,	City or Town, State, Zip	21133
Бащто	permit. Pages Department of Important: If i any injury or one		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State Haw	hins Cr	Tapel Chu Name and Addri 18 Lube	ess of Facility V	ingin C. Gr	ranhlinten	
	eath certificate be executed and attending physician and for use as the burial-transit	dicai Examiner	23a. Part 1. Enter 1.4 disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1.4 years of the cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	e cause on each line.	Jast nop of): Sulv		este vo	1 2 2	scoling	Approximate Interval Bestween Onset and Death
	0 0	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnanc 1□Live birth 2□Fetal di 4□Pregnant at time of dea	eath 3 □E	ctopic pregnand Other (specify)	у		23d. Date of deliver	ry Day Year
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UNISION OF VICAL RECORD  To the Hospital or Attending Physicien: The law requir within 24 hours effer death.  To the Funeral Director: Affer this certificate has been si completely filled in by the funeral director, page 2 should i	S D	To Be	25. Was case referred to medical examiner?  1  Yes 2 H	ospital: 1 ☐ fnpatient 2 ☐ EF	NOutpatient 8b. Time of	3LI DOA	her: ursing I	ath (Check only one	No 1 ☐ Yes Discrete 6 ☐ Other (Specify	
	el or Attending s efter death. il Director: Afte	Certification:	Tatural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) Injury Work?  1 □ Yes 2 □ No  28e. Place of Injury - At home, farm, street, factory, office 28f. Location					(Street and Number or Rural Route Number,	
	To the Hospital within 24 hours of the Funeral completely filled	Medical O	29a. Certifier (Cineck only one)  2 Medical Examir  29b. Signature and title of certifier	ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death o n and/or inve	stigation, in my	ime, date and place opinion, death occi	irred at the time, da	use(s) and manner as state and place, and due to	the cause(s)
6	F 3 F 8		30. Name and address of person who co	pleted cause of death (Item 2	3a) (Type, Pr				0 wings	
	Sta Registi		Tahoora Kawa 31. Date filed (Mooth Day Year) 200	32 Registrar's Signatu		de s			MDD	Ш7

Registrar DHMH 17 Rev 1/2001 07-03802 Branden Johnso

Mec

All Copies Are Legible

802 en Johnson		Please Type or Print in Black Indelible In State of Maryland / Department of	nealth and Montain.	, 5		007 1553			
	n	or State cistrar Decedent's Name (First, Middle,Last)	Death	Reg. N 2. Date of Death Month Da May 19, 2007		3. Time of Death 0028 hrs			
≟xaminer		Dan Maga Tohnson	b. City, Town, or Location of Death Rossville	1	Baltimore Co	ounty			
Funeral Director		Social Security Number   6. Sex   7. Age (In yrs. last birthday)   18 - 21 - 0842   1X M 2 F   26   Yrs.	If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Mir		I For	Birthplace (State or eigrMaryland Country)			
	Us	sual Residence of Decedent  10c. City, Town or Location (City, Town or Location)				10d. Inside City Limits 1 Yes 2 X No			
the Maryland a or 28a-f shov tified at once.	10	De. Street and Number  17 Juliet Lane	10f. Zip Code 21 236	10g, Citizen of What Country?  USA  U.Specify Yes or No-  14. Race - American Indian, Black,					
death with or items 23 must be no	11	1. Marital Status  1. Marrital Status  1. Marrital Status  1. Was Decedent Ever in U.S.  Armed Forces?  1. Yes Sive Year  1. Yes Sive Year  1. The sive Year	as Decedent of Hispanic Origin? ( fee, specify Cuban, Mexican, Puer Yes	to ruceii, o.c.,	White, etc Wh Specify:	nite			
2 hours after "natural", I Examiner	<u>:   :</u>	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Met	nt's Usual Occupation (Give kind o nost of working life. DO NOT use n er Mechanic	Kodiak Utili Corporatio					
215-0036 be filed within 72 hours nital Hygiene. rked other than "natu ent, the Medical Exan	<u>v</u>	12 17. Father's Name (First, Middle, Last) Timothy Johnson	er, City or Town,	State, Zip Code)					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medic	2 7	Timothy Johnson-father 2413	ng Address (Street and Number of Swindsor Road-Bostion (Name of cemetery, Institute of the property of the pro	altimore,	Maryland 20c. Location - Ci	21234			
ltimore, nit. Pages l at artment of He ortant: If ite		1 Burial 2 Cremation 3 Removal from State EVANS FUN 4 Donation 5 Other Specify:	IN SERVE BEAR  IN SERVE BEAR  Name and Address of Facility  VANS FUNERAL  ND CREMATION	CHAPEL SERVICES		arford Road ille,MD 21234			
/sician /Medical	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	ND CREMATION rethe mode of dying, such as cardi	SERVICES ac or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and Death			
Examiner		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.							
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
60, xate be executed only sician and reburial - transit	76	UNPENDED AMENDED  IF FEMALE: 23b, Was decedent pregnant in the 1 Live birth 2	23d. Date of delivery  Month Day Year						
Box 68760, e death certificate be exe the attending physician and for use as the burial -	Physician/Medic	past 12 months?  1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 Unknown	Other (Specify)			bute to the cause of death?			
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of Vital Recoling Physician: The law After this certificate has funeral director, page 2 s	n: To Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa  27 Manner of Death  28a. Date of Injury  28b. Tim	e of Injury 28c. Injury at Work?	No Motorcycle	e how injury occur e driver imp	red pact with vehicles			
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Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Modical Ca	28. Certifying Physician: 10 the best of examination and/or inventors one)  2 Medical Examiner:On the basis of examination and/or inventors and manner stated.	ce, and due to the ca	and due to the cause(s) and manner as stated.  In at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)					
	2	Mounte Brelshill	29c. License number O.C.M.E.		May 19, 2				
13	<u> </u>	Margarita Korell MD. Assistant Medical Sizzaturo	11 Penn Street, Baltimore	e, MD 21201					
Reg	Sta istra	te 31. Date lifet (Month), part 12/2007							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Dea 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nymber Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number 6. Sex last birthday) **Funeral** -18-9700 1 🗆 M Months Days Hours 1-20 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No ores Director Hou 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 K No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Janie ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5-23-07 Durdalk AB, Forest HII III 21. Signature of Funeral Service Licensee Sorvices-Boldin Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCL CARDIOVASCULAR EROTIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intriculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760, 🖈 Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION 1 Yes 2 No 3 Probably 4 Nonknown Be Completed RENAL (NSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. lace of Death Check onl one Other: Hospital: 2[P No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident efter death.

Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours efter

To the Funeral Dire

completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 BEL AR ABHYANKAR NORTH AVE 2. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

MAY 2

2 2007

	1	For State Registrar	State of	Marylan		rtment of H		and Me		giene	)7	165	537
Dharaista		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Day	Year	3. Time o	f Death
Physicia /Medica		Charlotte L. Jo	hnson					1	May 14,			1316	рм
Examine	r	4a. Facility Name (If not institution,				4b. City, Town, o				4c. County			
		Harford Memoria			last birthday)	Havre de	Grac		8. Date of Birth	Harf		alana /Ctata	or Corpies
Funeral Director		5. Social Security Number 215–44–1434	1 M 2 AF	61	Yrs.	Months Days	Hours	Min.	March 2	Year)	Cou	place (State ntry) vland	or roreign
		Usual Residence of Decedent		- 01					ilaren 2			) Lana	
show	. [	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside C	
the Mar	cto	Maryland Harfo	rd		Belo	camp							2X No
vith the Maryla t or 28a-f shor	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizen of V	Vhat Cou	ntry?	
ath w		4268 Cowan P1.	Linux n		0 1404	21017		-1-0 (0-1-		.S.A.	. A	can Indian.	
item item	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Marrie</li></ul>	12. Was Decede Armed Force ad 1 ☐ Yes 2	s?	.5.	Was Decedent of H f Yes, specify Cuba	an, Mexican	, Puerto F	lican, etc.)	Blac	k, White,		
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2 hou		15. Decedent	s Education		16a. Deced	lent's Usual Occup	ation	t of workin		16b. Kind of Bu	ısin <b>ess/</b> ln	dustry	
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d 2 should th and Mer 7 is mark traumatic		19a. Informant's Name/Relationsh		1 1		g Address (Street					State, ZIJ	code)	
Health Health em 27 ther tr	Ĭ,	Richard L. Jers 20a. Method of Disposition	scheid_(Hus	20b. F	Place of Disco	sition (Name of			MD ZIUI	20c. Location -	City or To	own, State	
Pages nent of int: If it iry or o		1  ☐ Burial 2 ☐ Cremation		are		hatory or other place hurch Cen		15/18	/2007 E	ylesvil			and
permit. Pages and 2 Department of Health a Important: if item 27 is any injury or other trea	Ī	4 □ Donation 5 □ Other (Sp. 21. Signeture of Funeral Service L		^			1 = 100		-	•			
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The law requires that the death certificat the has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 □ Unknown	23c. If yes, outco 1 ∐Live birth 4 ☐ Pregnan 9 ☐ Unknow	n 2 ∏ Feta it at time of d	ildeath 3□	Ectopic pregnancy Other (specify)	(			23d. Dai	te of deliv	ery Day	Year
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or A effer Direction by	ert	4 ☐ Homicide determi		, etc. (Specia		set, lactory, ornoe		1	City or Tow			a, 710 at 0 710.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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To the To the comple	Me	29b. Signalure and title of certifier			n.A	29c. Licens	36°	<b>7</b> 40		29d. Date signe	d (Month,	Day, Year)	
3		30. Name and address of person of the control of th	who completed cause	of Seal (ited	m 23a) (Type,	Print) HARP V AVEU	ORD I	MEM	ORINE OF DE	CARAC	PIT	210	501 78
Stat Registra		31. Date filed (Month, Day, Year)	32. Reg	istrar's Sign	ature	Carl 1		V3VI					<b>-</b>

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 01:15AM MARG (7 2007 - DUISE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SI HAM HOSPITAL BALTIMORE BALTIMORE CTTY OF If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day,
Min. (Month, Day, Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 M 2 F 220-01-215 MAR Director LAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the M-dical Examiner must be notified at 1XYes 2 □ No Director MARIJANS 10e. Street and Number Citizen of What Country? IWORTH 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Maonco. Elementary/Secondary (0-12) College (1-4or 5+) 2 +HGRADE 1AKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TOSEPH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGHA JOHNSON GRANDDA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. Pages 1 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of 21. Signature of Funeral Service Licensee JR. FUNERAL HOME N. FULTON AVE. 1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE RELIAI **Physician** FAILURE SAMIS /Medical Due to (or as a consequence of) Examiner BRMS CLOSTRIDIUM DIFFICILE COUN'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%bunial-trar Due to (or as a consequence of) physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COAGULOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed BLEED THE GASTROILLESHULE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an page 2 s autopsy performed? Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation safter dea.
safter dea.
seral Director; ₽ 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospital or Attending Physician: 24 hours a within 24 hou

To the Fune
completely fi

HOSTHO

77

Medical and manner stated 29c. License number 29b. Signature and title of certifier IMD 64621

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SABRUELA STABOIMD, SINAI HOSPITAL OF BALTIMORF

State Registrar

3

31. Date filed (Month, Day, Year) MAY 2 2 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 Par Year **Physician** SONG Kim ZOOF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County Baynesville Cromwell Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 17,1934 North Korea Months Days Hours 1 **X**M 2 □ F 214-68-1740 August Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 28a-f show Examiner must be notified at 1⊠Yes 2 No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 21201 United States 1017 Cathedral Street 23a Pages 1 and 2 should be filed within 72 hours after death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married P 1 ☐ Yes 2 Ho Specify: Baltimore, Maryland 21215-0036 Specify: Korean þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Owner Cook 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gae Sun Yea Gan Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cockeysville, Maryland 21030 216 Wickersham Way Mr. Heung Sick Kim (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 21, 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licens 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part. Enter the disease shock, of heart failure. Immediate Cause Final disease or condition resulting in death) Approximate Interval Between Onset and Death HOURS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3∐ DOA 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 atural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 3□ Suicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be

the

6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

CROMWELL CEN 8710 EMGE RO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10M Elizabeth Marie Kendall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMOR 01-BALTIMOR Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 217-07-1892 Sept. 10,1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2∭XNo Specify: Specify: White Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Emma Hubbard Frank J. Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth Dew (Son) 818 Litchfield Cir. Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 05-18-2007 Suitland, Maryland 21. Signature of Funeral 85 Ce Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): PNEUMONIA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy PULMONARY TOISEASE perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Depatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28b. Time of 28a, Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

as the burial P.O. Box 68760. use a for Division or Vital Records, page this funeral after death the filled in by within 24 hours a

To the Funeral I

completely filled

**Funeral** 

Director

r 28a-f show notified at

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I

s 1 and 2 should be fill f Health and Mental H tem 27 Is marked ott

Pages 1

**Physician** /Medical

Examiner

Baltimore,

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

SINA HUSPITAL OF 32 Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb. 9868 6-4-07 vt.

			1 = State Registrar	State of Marylar		rtificate of I		Re	g. No.	7	16541
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		THOMAS PATRIC					May 18	1		6:12 P M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County o		
			MANOR CARE, RUXTO  5. Social Security Number 6. Sec		last hirthday)	TOW If Under 1 Year	SON If Under 24 Hrs.	8 Date of Birth	Balti	nore	County ace (State or Foreign
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			Usual Residence of Decedent	03				INOV 10,	1923	_ Mary	land
	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				100	d. Inside City Limits
	Ba-f.s	cto	Maryland Baltimore	County	Tot	wson					1 ☐ Yes 2 🙀 No
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	ter dea	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 GYes 2 □ No	1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	o Rican, etc.)		- Americar , White, et	
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	1 an Heal	16	Kathleen K. Garrett  20a. Method of Disposition	20b. I	Place of Dispo	it of Bour	!	, Palmyra	, Virgi	nía 2 City or Tow	22963 m. State
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Baltimore,			'4 □ Donation 5 □ Other (Specify)  21. Signature of Fure #1 Secretary		The second second	ount Crem 2. Name and Addres		22/200/	Baltin	iore,	Maryland
Ba	permit. Departr Import eny inj		Martin D. Law	SON	1	MITCHELL-	${ t WIEDEFEL}$				1 2 1 2
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the dea	th. Do not ent	5500 York er the mode of dyin	g, such as cardiad	or respiratory arre	st,	1	Approximate nterval Between
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-	/Medical		disease or condition resulting in death)	Due to (or as a consec	quence of):	VICUL	WIN /	11161	0011	/	Youks.
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0	D is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	luence of):						
12.	and P-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	ulence of):						
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687	icate phys s the	edicai									
Вох	death certifi e attending p ad for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn					23d. Date	of delivery	,
m.	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c		JEctopic pregnancy ] Other (specify)	·		Mon	th D	Day Year
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isi	or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome form etc		Yes 2□No	28f. Location (Str	eet and Numbe	r or Pumil I	Pouto Number
Division	I or Attend after death Director: , I in by the f	ertification	4 Homicide determined	building, etc. (Special	fy)	eet, factory, office		City or Town		r or murai r	noble ivambel,
	Hospital 24 hours 2 Funerel 1 tely filled	0	29a. Certifier 1X Certifying Physical Certification Physical Certificat	sician: To the best of my kno	owledge, death	occurred at the tim	ne, date and place	and due to the ca	use(s) and man	ner as stat	ted.
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	To the Hospital of within 24 hours at To the Funerel D completely filled in	Me	29b. Signature and title of certifier	1 0		29c. License	number	29	d. Date signed	(Month, Da	ay, Year)
	_		MICON	edim		D-6	01284	19	5-19	-07	7
	9		30. Name and address of person who co	impleted cause of death (Iter	п 23а) (Туре,	29c. License D-C	12	T		11	21721
			31. Date filed (Month Only Year) 2. 7	) ( / / / / ) . 32 Registrar's Sign	1000	OSIE	KO	10005	on 1	11)	21264
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DHMH 17 Rev 1/2001

State Registrar Year)

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31. Date filed (Month. Day.

ORIGINAL

2. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Aideh Kobler 3:109 M Mai 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard **Howard County General Hospital** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) December 25, 1921 9. Birthplace (State or Foreign Country) China 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 💢 F 85 212-52-2890 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Maryland Howard Columbia Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 10637 Hickory Crest Lane death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. þ Specify: 3 Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental Hisnt: If Item 27 is marked oth Be John Wu Mei unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau 7126 Willow Brook Lane Columbia, Maryland 21046 Son Mr. Ben Kobler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/27/07 Pikesville, Maryland Druid Ridge Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility nature of Funeral Service License Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Delirium /Medical Examiner 5. I.A. D. M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off that the death certificate be executed physician and s the burial-trans gastria rancino Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use intribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 NO P 1 hpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and Aftle of certifier

31. Date filed (Month)

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ellens

Carlson

10700

29d. Date signed (Month, Day, Year)

07-03809 Scott Edward Klima

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		or State					Certi	ficate of	Death					Reg. No	).		3. Time of Death
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uneral		104 Bliss Lar Social Security Nu		6. Sex		7. Age (I	n yrs. las	t birthday)	If Under		If Under	24Hrs.	8. Date of	Birth (MI	M/DD/YYYY	Fore	-1- A
irector		15-13-85		1 <u>X</u> M	2F		22	Yrs.		Days	1100.0		July	20	1984		ountry) MD
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should be filed within 72 hours after dean with the mary-and and Mental Hygiener and Mental Hygiener 17 is marked other than "natural", or items 23a or 28a-1 she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		Marital Status		1	2. Was De		ver in U.S	6. 13. Wa	s Decedent es, specify	t of Hisr	nanic Orig	in? ( Spe	ecify Yes or Rican, etc.)	No-		e - Ame	erican Indian, Black,
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and 2 s ealth ar tem 27 traums		a Method of Dist	oosition					Place of Dispo	sition (Nam	e of cer	metery,		Date 23,	2	0c. Location	n - City	or Town, State
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Regist			MAY	22	2007	Also.	gue.	Dr.	Sec.	_							

State of Maryland / Department of Health and Mental Hygiene-1 = Statemend 29d, per MD, g869, 7/6/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Gertrude Kootz May 2007 1:30a 6 "/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ XF Hours Min. Months 69 165-30-3676 PA July 13 1037 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10d. Inside City Limits PA Philadelphia Philadelphia 1 ☐ Yes 2 🙀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9660 Pine Road 19115 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) homemaker domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Conneen Ethel Hennessy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Kootz (son) 6956 Cable Dr., Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Forest Hills Cemetery 5-19-07 Philadelphia, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Day Haight Allert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardrae /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify). 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 1∏ Yes 2 🕰 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Kinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 Tyes 2 No neral Director: A investigation death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🛕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 2007 29b. Signature and title of certifier MO ecl. 52035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westmenister Horol Avenue CHACKO 291 6 (NU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

			State of Maryland State Amend Item 29d per dr., g Registrar	d / Depa 867 <b>.0</b> 5	irtment of H 122/07dbl tificate of I	ealth and M	lental Hy	giene Reg. No. 2	07	15546
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21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired um Fitter	1)		Shi	p Bui	lder
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sio	Attendi death. ctor: A y the fu	catio	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At ho	omo form at		Yes 2 □ No	204 Logotion /	Chronica and Misses	has as Due	al Cauta Number
Division	or Attendate death Director:	Certification:	4 Homicide determined building, etc. (Specific		eet, factory, office			wn, State)	ber or naid	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my kno (Check only 2 Medical Examiner: On the basis of examina							
	To the H within 24 To the F complete	Medical	one) and manner stated.		29c. Licens	<u> </u>		29d. Date signe		
	Mii V		29b. Signature and title of certifier		25	5506	I	May 10,	2007	7
	I		30. Name and address of person who completed cause of death (Item 8 ) 31. Date filed (Month, Day, Year) 32. Registrar's Signal MAY 2 2 2007	n 23a) (Type,	Print)			4 1		/
	15		Ferties no 8/09 A	tels	High	my Pa	eden	e / has	plan	8 21/22
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LAdini	illei	9794 Martingham				ichael's		Talbot	
Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. last birthday,	If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreigr untry)
Director		214-38-5545	1XM 2□F	81 Yrs.	Months Days	Hours Min.	Apr 21,	1926 Mar	yland
pu »	7	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L					
aryla •hov	5	,							10d. Inside City Limits
he M	Director	MD Talbot  10e. Street and Number		St. Mi	chael's				1 ☐ Yes 2√ No
with a or	5		0:1		10f. Zip Code		11	0g. Citizen of What Co	untry?
eath	eral	9794 Martingham	12. Was Decedent	Ever in II S 12		21663	porty Voc or No	USA 14. Race - Ame	ioon Indian
Vinitin 72 hours after death with the Maryland jiene. Fihan "natural", or Itama 23a or 28a-f show the Moulcal Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
nd 2 should be filed within 72 hours aft ath and Mental Hygiene. 27 is marked other than "natural", or r traumatic evant, the Muulcal Exarti	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business/I	ndustry
hin 7	pie	(Specify only highest grant Elementary/Secondary (0-12)	ade completed)  College (1-4 or :	(Give	kind of work done DO NOT use retire	during most of work ed)	ring		•
d wit	0	12	5+		physician	1		healthcare	
be filed that Hygie od other i	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name	e (First, Middle, N	Maiden Sumame)	
should be and Mental amarked o	2	Watson Kime				Lucille			
s 1 and 2 should if Health and Men Item 27 is marke other traumatic	6	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Stree	t and Number or Run	al Route Number.	City or Town, State, Z	ip Code)
1 and Health tem 27		Sybil Kime/spouse	:			am Circle		hael's MD	21663
Pege ent o nt:#		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif	(y)		osition (Name of matory or other pla	ace)	Date	20c. Location - City or I	Fown, State
permit. Depertmine imports any inju		21. Signatur & Juneral Price Lice	Wade, Dir		Name and Addr ate Anat	ess of Facility Omy Board MD 2120	655 W.	Baltimore :	Street
Pnysician /Medical		23a. Pad 1. Enter the disease, or/com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not ententententententententententententente	ter the mode of dy	ing, such as cardiac	or respiratory arre	ist,	Approximate Interval Between Onset and Death
Examiner			COR	ONANY AT	HENOSEL	ERUSIS			
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		a consequence of):					
ificate be executed g physicien and as the burial-transit	Examiner	that initiated events	c						
e exe ien a urial-	Ä	resulting in death) Last	Due to (or as	a consequence of):					
ate b hysic he bt	edicai		_ d						
	Med	IF FEMALE:				17.5			
The law requires that the death certif ste has been signed by the ettending pege 2 should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	;y		23d. Date of deliver Month	very Day Year
w requires that been signed b should be deta	ed by Pi	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause gr	ven in Part I.		accoluse contribute to	
: The law r cete has be pege 2 sh	Completed						24a. Was an autopsy perform	prior to c ed? death?	opsy findings available ompletion of cause of
ician Sertifi ector	Be	25. Was case referred to medical examiner?	Manufali		10	26. Place of Death	Check only one	1	
Attanding Physician: r death. actor: After this certifice by the funeral director;	은	1 Yes 2000No		nt 2 ER/Outpatier	IL 3 L DON			nce 6 Other (Spec	ify)
Jing After funer	0	1 Natural 5 Pending	28a. Date of Inju (Month, Day	ry 28b. Time of Injury	Wo		28d. Describe hov	w injury occurred	
death death tor: the	lcat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	201 1 11 12		
urs after or A	Certification;	4 Homicide determined	building, et				City or Town,		
To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Aedical	one) 2 Medicar Exam	ysician: To the best niner: On the basis of and manner sta	of my knowledge, death examination and/or in- ated.	vestigation, in my	opinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
5 × 5 × 5	Σ	29b. Signature and title of certifier	3//1/1	,	29c. Licens			d. Date signed (Month,	
		- Javier	V (Mun.		Do	0057908		5/15/07	7
		30. Name and address of person who	V. PATI	ENSON MD	Print) SNS	· TALBOT	-51	5/15/07 35 MICHAZ	ers Mo
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 2 2007	32. Registra	ar's Signature	12				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Ham Wille Lausson 05 (Hay) 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GEN WHO 0 umhia 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 250-30-1091 Months 1X M 2□ F Hours 01/16/1920 87 CAROLINA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD HOWARD **JESSUP** 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7887 NORDAU COURT 20794 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1 Yes, Give Year or Dates: ARM 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. US 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced ARMY BLACK 16a. Decedent's Usuai Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MARYLAND GLASS Elementary/Secondary (0-12) College (1-4or 5+) GLASSWARE TECHNICIAN CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS LAWSON SYLVIA DOUGHERTY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANETTE LAWSON / DAUGHTER 7887 NORDAU COURT, JESSUP, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State METRO 5/21/07 CREMATORY CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death edi. e Cause (Final or condition ting in death) Due to (or as a consequence of): Due to (or a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2. ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

the burial-tran and Division or Vital Records, P.O. Box 68760 attending physician The law requires that the death certificate be

Examine Physician/Medical Be ၉ Certification:

**Physician** 

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

must be notified at

Director

Funeral

þ

Completed

Be

2

with the Maryland

ģ Completed

Hospital or Attending Physician: I Director: After to d in by the funera n 24 hours aft le Funeral D letely filled ir To the Fund completely f within 2. To the I

> State Registrar

Medical

29b. Signature and title of certifier reman

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Columbia 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 2 2007

and manner stated

			For State	State	of Marylan			of Hea		/lental l				
į	Physici	an	Registrar  1. Decedent's Name (First, Middle DOROTHY		HMANN	- 001	incate	or De	alli	2. Date o	f Death	. No.	007°	3. Time of Death 7:20 A M
)	/Medio Examin		4a. Facility Name (If not institution	, give street and n	umber)	<b></b>	4b. City, T		ation of Death			4c. Count	y of Death	
. siji.	Funeral		FOREST HILL HEA  5. Social Security Number	LTH AND 1	REHABILI  7. Age (In yrs.		If Under 1		ST HILL Under 24 Hrs.	8. Date of	f Birth		HARFO	RD lace (State or Foreign
l.	Director		213-20-1084	1□M 2 <b>X</b> F	82	Yrs.	Months	Days H	ours Min.	Oct.	, Day, Y		Mary.	try)
	rland ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cif	y, Town or Lo	cation						1	0d. Inside City Limits
	e Man la-f sh tifled a	ctor	Maryland Harfo	ord		Forest	: Hill							1 □ Yes 2 No
	with that or 28	Director	10e. Street and Number				10f. Zip (		-		10g	. Citizen of	What Coun	try?
	ms 23	Funeral	1607 Belvue Driv	12. Was De	cedent Ever in U	.S. 13. V		.050 ent of Hispar	nic Origin? (Sp	ecify Yes or			ce - America	
920	be filed within 72 hours after death with the Maryland ital hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 □ Never Married 2 □ Marri 3 🛱 Widowed 4 □ Divorced	Armed Fed 1 □ Yes	; 2 <b>∑</b> No Bive		f Yes, speci I □ Yes 2	_	lexicañ, Puèrto pec <i>ify:</i>	Rićan, etc.	)		ck, White, 6 fy: <b>Whit</b>	
Maryland 21215-0036	72 ho "natur dical f	Completed	15. Decedent (Specify only highes	s Education t grade completed	1)	I (Give	kind of work	Occupation done during	ı g most of work	king	16	b. Kind of B	usiness/Ind	fustry
121	filed within 72 Hygiene. Ither than "nat	omp	Elementary/Secondary (0-12)	College	(1-4or 5+)	Secret	oo not use cary	retired)			St	eamfi	tters	1ocal 438
מפי	e filed al Hygi d other event, tl	BeC	17. Father's Name (First, Middle, I	ast)		1		18.	Mother's Nam	e (First, Mic	idle, Ma	iden Surnaı	me)	
Z Za	es 1 and 2 should be of Health and Mental item 27 is marked or other traumatic eve	2	Frank F. Fialko			1401 14 77			arlotte					
	and 2 sl ealth an n 27 is r ier traur	3	19a. Informant's Name/Relationsh Susan Wilson (Da						Number or Rui ce Fore					Code)
altimore,	ages 1 ar of Hear or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			Place of Dispos cemetery, cren	sition (Name	e of		Date			- City or To	wn, State
Ĕ	. Pages tment of tant: If It jury or o		4 ☐ Donation 5 ☐ Other (Sp	ecify)	n State	. Air Me	emoria	1 Gar		5,200	7 Be	1 Air	, Mar	yland
Bai	permit. Pag Department Important: I any Injury o	8 9	21. Signature of Funeral Service I	icensee	7			Address of O W. 1	<sup>Facility</sup> So MacPhai					of Bel Air 014
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ente	er the mode	of dying, su	ich as cardiac	or respirato	ry arrest	,		Approximate Interval Between Onset and Death
,	Physician /Medical		immediate Cause (Final disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	lem	luce /	chep					Onset and Death
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8/60,	ate be hysicia the bur	dical		d										
٥	leath certific attending pl	/Med	IF FEMALE:	23c If yes o	utcome pf pregna	ancy.					-		1	
O. BOX	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the bunal-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	1 ☐Live	birth 2 ☐ Feta gnant at time of d	Ideath 3□	Ectopic pre Other (spe				-		ite of deliver	ry Day Year
ນັ	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditio	ns contributing to	death but not resi	ulting in the un	derlying cau	use given in	Part i.	23e. D	id tobac	co use con	tribute to the	e cause of death?
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VItal	sician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				0	Place of Deat					
0	g Physer this eral di	ت. ح	1 Yes No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of		c. Injury at Work?	Nursing Ho	me 5 ☐ R 28d. Descri				)
NOIS NOIS	ending ath. or: Afte he fun	ation	Natural 5 Pending investigation	ation	nth, Day Year)	Injury	М	Work? 1 ☐ Yes				, , , , , , , , , , , , , , , , , , , ,		
UIVISION	or Atta	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 28e. Plac	e of injury - At ho ding, etc. (Specif	ome, farm, stre	et, factory,	office			n (Stree Town, S		er or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, is		29a. Certifier 1 Certifying	Physician: To th	e best of my kno	wledge, death	occurred at	t the time, da	ate and place.	and due to	the caus	e(s) and m	anner as sta	ated.
	the Ho nin 24 h the Fu rpletely	edical	(Check only 2 ☐ Medical E	xaminer: On the	basis of examina nner stated.	tion and/or inv	estigation, i	in my opinio	n, death occur	red at the tir	me, date	and place,	and due to	the cause(s)
	With To 1	Σ	29b. Signature and title of certifier	0			29c.	License num	nber				d <i>(Month, E</i>	
•	15		30. Name and address of person v	the completed co	ise of death (Item	23a) /Type 5		D 3 3	257		m	Ay 10	1,20	-1
	15		DR. DAVID DUNN	615 MA	CPHAIL R	ROAD	BEL A	AIR, M	ش 210	14				
	Sta Registra	_	31. Date filed (Month, Day, Year)	2007	Registrar's Signa	ture	W							

DHMH 17 Rev 1/2001

		For State	State of Ma	-	-			and Me	ental Hy	giene	0 0	A	1-15
1	-	Registrar  1. Decedent's Name (First, Middle)	e. Last)		Certific	ate of	Death	T	2. Date of De	Reg. No	1 U	1/	3. Time of Death
Physic		Sophia Helen Li							Month	Da		Year 2007	M
/Med Exam		4a. Facility Name (If not institution	n, give street and number)		4b. 0	ity, Town, o	r Location o		May		. County of		1:00p
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Funera Director		5. Social Security Number 482-16-4069	6. Sex 7. Ag	e (In yrs. last birt	Yrs. Mon	ths Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di May 21	ay, Year)		9. Birthpla Countr Iowa	ace (State or Foreign ry)
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10	d. Inside City Limits
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or 28.	Direc	10e. Street and Number			10f.	Zip Code	_			_	tizen of Wh	nat Counti	ry?
s 23a	ral	7486 Montevided			1	794		1.0.0		U.S.		A	- 1- 41
ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Mari 3 ▼Widowed 4 □ Divorced	ied 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		If Yes,	specify Cub	an, Mexican  Specify:	gin? (Spec n, Puerto F	cify Yes or Ne Rican, etc.)	0-		white, e	tc.
21215-0036 d within 72 hours af giene. er than "natural", or the Medical Exami	Completed	15. Deceden	t's Education st grade completed)	16a.	Decedent's I (Give kind o			t of workin	a	16b. K	ind of Bus	iness/Indu	ustry
vithin ne.	ald m	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NO	T use retire	d) -	O WOTAIN	g	_			
d 2	S	12 17. Father's Name ( <i>First, Middle</i> ,	Last)	Leg	gal Se	cretar	( )	r's Name	(First, Middle	Law . Maider		)	
Maryland Id 2 should be file Ith and Mental Hy 27 is marked othe traumatic event,	To Be	Steve William M	liletich						icia K			,	
Tary 2 should and No.	-	19a. Informant's Name/Relations	hip (Type. Print) Daugh	nter 19b.	Mailing Add	ress (Street			Route Numb			tate, Zip C	Code)
e, M 1 and 2 Health em 27 l		Mary Elizabeth	Krok-Januk	77.	30 Me1	low C	ourt I		er MD				
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If Item: any Injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		20b. Place of cemeter					ate		ocation - C	,	
Baltimol permit. Pages Department of Important: If it any Injury or once.		4 □ Donation 5 □ Other (S		Loudon				5-23-		ваті	limor	e, Ma	aryland
Balt permit. Departimports any Inji		Noan 20	XVIIXXXXX		1328	ose Fi Sulph	ıneral nur Sp	Home	e, Inc Rd. A	rbut	119 MC	) 212	27
	y)	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death Do n	ot enter the	mode of dyir	ng, such as	cardiac or	respiratory a	arrest,			Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):		,						
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. Box 68/60, death certificate be executed e attending physician and d for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence o	of):								
687 ficate physics the	edical		d										
BOX eath certi	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 ☐ Fetal death	2 □Eoton	ic pregnanc					23d. Date	of deliver	y
COrdS, P.O. BOX to require that the death certificate is signed by the attending should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at			(specify)	у				Mont	th [	Day Year
that the ad by the detache		Part II. Other significant conditi	ons contributing to death b	ut not resulting in	the underlying	na cause aiv	en in Part I.		23e. Did	tobacco	use contrib	oute to the	e cause of death?
Hecords, P The law requires that tte has been signed b	d by					3			1 🗆	Yes 2	No 3	B □ Proba	bly 4 ∏Unknown
aw rec	Completed								24a. Was		24b. W	ere autops	sy findings available
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On or VItal Hoding Physician: The Transfer this certificate his teneral director, page	Be	25. Was case referred to medica examiner?						of Death	(Check only	one)			
OF Physi rthis c	2	1 ☐ Yes 2 No 27 Manner of Death	Hospital: 1 ☐ Inpatie			DOA Oth	4 LJ Nu	rsing Hom	Res Bd. Describe		6 □Other		
oding th. : After	tion	Natural 5 Pendir	(Month, Day		njury M	Wor	rk? Yes 2∐1		od. Describe	now inju	ry occurred	u	
UIVISION OF VITA within 24 hours after death.  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, to completely filled in by the funeral director, to	Certification:	3 Suicide 6 Could 4 Homicide determ	not be and place of init	ury - At home, far c. <i>(Specify)</i>	m, street, fac	ctory, office		28	Bf. Location (	Street ar	nd Number	or Rural	Route Number,
spital of ours af ours af filled i		29a. Certifier Certifyin	ng Physician: To the best	of my knowledge.	death occur	red at the ti	me, date an	d place a	nd due to the	Cause/s	) and man	ner ac eta	ited
ne Hos n 24 h ne Fur	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination and	d/or investiga	ition, in my	opinion, dea	th occurre	d at the time	, date an	d place, ar	nd due to	the cause(s)
To the within To the Comp.	M	29b. Signature and title of certified	1 N	- A !		29c. Licens	se number			29d. Da	te signed	(Month, D	Sy Year)
		6-7-	vy ice				159	100	1-1	M	ory	21	2007
10		30. Name and address of person	nimy	CADI	Type, Print)	3a3	70	\$	Ha	200	1D	2/2	reed 125
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Land	* 9							
DHMH 17 Rev 1/	2001	MAYZ	a CUUI Jillings	es so	A CONTRACTOR								

12

-uBBehysen

。State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Son

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** May 2007 05:45 Elsie G. Leonard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genisis Elder Care <u>Severna Park</u> <u> Anne Arundel</u> 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F NC Director 90 242-07-4778 July 10, 1916 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Glen Burnie Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 241 Margate Drive 21060 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Nidowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Moving Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivan Sisk Sally Spry P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traumonce. Jerry Leonard (son) 903 Sunny Brook Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 5/21/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEROSCIEROTIC CARDION ASCULAR DIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transi Due to (or as a consequence of) P.O. Box 68760, physician the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed k d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours at er dea h.

To the Funeral Director A
completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The deciral Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBLIDE RD. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year William Leaman May 18 2007 10:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD Masonic Home Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral ★**□ M 2□ F 207-05-7186 89 Director PA Oct. 6 1918 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar wast be notified at Director 1 ☐ Yes 2 No Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 19 Greentree Dr. 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No white Completed by Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Builder Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hig Important: If Item 27 is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles E. Leaman Ida Weatley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine A. Brengle/daughter 723 Grady Lane, Belair, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/21/07 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Memoxrial Gardens Timonium, MD 21. Signature of Europe 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael 1 Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Femur **Physician** trac Tuno /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as t signed by the attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Thoms 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy perform this certificate 2. No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of after death. 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural tal 12/07' 1 🗀 Yes UNKnow 2X Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide nursing Home MUTSING HOME

Carteys like MT ZIC'SC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hours a

To the Funeral I 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21,200 MX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Count

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#196. perFH, G867, 5/29/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 19, 2:30P M 2007 Fenwick Lewis Sr. May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie

If Under 1 Year | If Under 24 Hrs. |

Months | Days | Hours | Min. Anne Arundel 1206 Branch Lane 8. Date of Birth (Month, Day, Year)
Dec. 30,1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Yrs. 72 MD 219-30-5306 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 by Funeral 1206 Branch Lane permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Master Sergeant U.S.Air Force 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ferdinand R. Lewis 2 Virginia Ederhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Reach Lane Clen Burnie, MD. 21061
Lane Clen Burnie, Manyland 2
ion (Name of Date 20c. Location) Mrs. Marie A. Lewis /Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 24, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2007 Stevensville, MD Chesapeake Cremation 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licenses Second Avenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mark uf Kun, mp P54574 05,21,2007 MARK KIM MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

NORTH CRAIN HWY GA

2007

31. Date filed (Month, Day, Year)

32 Registrar's Signature

GLEN BURNIS MD

			State of Maryland / Department of Health and I = State Amend #22, perFH, 6807, 5/22/0/11 Certificate of Death	Mental Hygie	ne 007	16555
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia		Rufus J Lee McNeill	05/2	0/2007	7:00 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat	1	4c. County of Dea	
	LAGIIIII	٠.	6809 Lenbern Rd Guma 04	K	Balt	inone
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		9. Bi	rthplace (State or Foreign ountry)
	Director		239-42-0334 1PM 20F 79 Yrs. Months Days Hours Min.	6/5/1	927	NC
	pu ,		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
	anyla •hov	-				1 Yes 2 H
	28e-1	Director	10e. Street and Number 10f. Zip Code	100	. Citizen of What C	
	with the or	ក់	6809 Lenbern Rd. 21207	iog	USA	ourniy:
	eeth	Funeral		Specify Yes or No-	14. Race - Am	encan Indian.
	ter d	F	Armed Eerces? If Yes, specify Cuban, Mexican, Puen	to Rican, etc.)	Black, Wh	
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Š	within 72 hours efter deeth with the Maryland ene. Inten "naturel", or items 23a or 28e-f ehow the Madical Examinar must be notified a	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	16	b. Kind of Busines	s/industry
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	be filed htal Hygid od other event, t	Be		me (First, Middle, Ma.		J
<u> </u>	should ind Men marke umatic	ပ္		a mc		
Maryland	~ ~ ~		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri Lilly E. Mc Neill (wife) (809 Lembern 1	urai Houte Number, C	ity or Town, State,	21207
	1 and 1 Health Iem 27 other tr	1	20a. Method Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City of	- MD .21207
و	Pages nent of I int: if ite				11.3.6	mills, mo
altimore,	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Specify) Grown Some Forest 5			
Ba	permit. Departi Import eny inj once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  5151 Baltimore National	il Vike Balti	more, MD Z	229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	c or respiratory arrest		Approximate
	Ohusisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			Interval Between Onset and Death
П	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):			11/1/1/ 1/19/
	Examiner					
		ner	Sequentially list conditions, If any, reacing to immediate cause. Enter Underlying			
	cuted nd iransi	Examiner	Cause (Disease or injury that initiated events c.			
Ö,	e exe cien a urial-		resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical	d			
9 ×	that the death certifics ed by the attending pt detached for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		001 D(	P.
Вох	atten for us	lan	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of d Month	elivery Day Year
P.O.	the d	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
	law requires that the es been signed by th 2 should be detache	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Vital Records,	w requires that s been signed t should be det	d by	NA_	1 ☐ Yes	2 No 3 1	Probably 4 Amnown
Ö	s bee	Set	CAN)	24a. Was an	24b. Were	autopsy findings available
Re	The lav	Completed		autopsy	d/ death	completion of cause of
ta	an: tifice tor, p	a	25. Was case referred to medical 26. Place of De	1 Yes 2 ath (Check only one)	3 10 10 10	
<u> </u>	Physician: this certific ral director,	ToB	examiner?  1   Yes   2   No	./	ce 6 □Other (Sp	ecify)
n of	ng Ph ter th neral		27. Manner of Death 1 DNatural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how	intury occurred	
Division	Attending r death. ector: After by the fune	ätk	2 Accident investigation M 1 Yes 2 No			
ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,		Rural Route Number,
	urs e aral D					
	Hospital 24 hours e Funaral C	edical	29a. Certifier  (Check only)    Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only)   Check only   Check	e, and due to the cau curred at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours eiter death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	Med	one) and manner stated.  29b. Signature and title of certifier. 29c. License number	290	I. Date signed (Mo	nth/Dey, Year)
	F 3 F 8		May W. Vaino MA DIANIO		5/711	01
z	V		30. Name and address of prefson who completed cause of death (tjern/23a) (Type, Print)	11/2	12010	//
4	) [		John Palm 4311 Underwood KA	12110.	11/1 7	1218
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	241.11	The of	
	Regist	rar	MAY 2 2 2007 May to Soule	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For Amend #2, perMD, g868, 6/5/07 1T Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Howard Miles 17 + 2007 7:25 PM May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Woodbridge Valley Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, May25, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days 216-05-5033 93 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f sh notified MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21228 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be nonce. 1527 Rolling Road **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ŽŽ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛚 No Specify **∂** White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Bakery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Miles Jennie Barnes ္ပ 19a. Informant's Name/Relationship (Type. Print) Diana Gately/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Winstead Ct Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State 5/22/07 Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee C. 22. Name and Address of Facility
MacNabb Funeral Home, P.A. Todd Dring 301 Frederick Rd Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perfori 2 No 1□ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated. 29b. Signature and title 29c. License number 29d. Date signed, (Month, Day, Year) of certi an 30. Name of person v

Registrar

State

31. Date filed (Month, Day, Year)

MAY 2 2

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03733 2117 1135 State of Maryland / Department of Health and Mental Hygiene Anastasia Violett Moran Certificate of Death Reg. No. 1- For State 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Year Physician/ Month Da May 16, 2007 0823 hrs Examiner Anastasia Violett Moran 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2038 Griffif Avenue If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Country) MD 216-75-4533 May 3, 2006 2 X F 1 Director М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No Baltimore N/A MD or items 23a or 28a-f show Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21230 U.S.A. 2038 Griffis Avenue 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White etc. Armed Forces? 1 X Never Married 2 Married white 2 X No Yes Specify. 4 Divorced If Yes, Give Year Yes 2 X No specify: permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Never Worked College (1-4 or 5+ Elementary/Secondary (0-12) Never Worked 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessica Erin Lockner Thomas Daniel Moran, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2038 Griffis Avenue Baltimore Maryland 21230 Jessica E. Shoop/Mother Baltimore, MD 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition West Arundel Crematory 5-21-2007 Odenton, Maryland Burial 2 X Cremation 3 Removal from State Donation 5 Other Specific 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne . Signature of Funeral Service Li 2719 Hammonds Ferry Road Lansdowne Maryland 21227 the disease, or complications that caused the death point enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart only one cause on each line. Solden unexplained death in childhood

e (Final disease a. Sudden infant death syndrome Approximate Interval Between Onset and ysician failure. List only one cause on each line. Death Medical Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and X AMENDED #23a,27, perME, 2870, 8/16/07 TT #23a,27, perME, 8609, 7727/07 TT hysician/Medical signed by the attending physician a be detached for use as the burial -X UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown þ σ, 24b. Were autopsy findings available Completed 24a. Was an Records, has been a prior to completion of cause of autopsy performed? death? 1 🗸 Yes No ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, Division of Vital Be Nursing Home 5 Residence 6 Other: Scene Other<sub>4</sub> Hospital: examiner? DOA Inpatient 2 ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death <u>S</u> Yes 2 No 1 X Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation Certificat 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 17, 2007

DHMH 17 Rev 1/2001

State

Registrar

Nio

32 Registrar's Signature

Assistant Medical Examiner

ade the the

004

30. Name and address of person who completed cause of death (Item 23a)

2007

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month 20 Ž867 Fthe1 J. Miller 11:19 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month Day ) ADY1 27 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🖫 F 76 216-28-8048 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ YNo Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8023 Belhaven Avenue 21122 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Waste Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Atkins Florence Germmick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8023 Belhaven Avenue, Pasadena, MD 21122 Carroll Miller (spouse) Date 24 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) |Glen Haven Cemetery 2007 Glen Burnie, Maryland 21. Signature of Euperal S Nio Lic nsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or conscications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NTRACENTERAL HEMORRHAGE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1/2 Inpatien

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Is marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other trainmeth

other traumatic event,

hours after death

filed within 72

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

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I Records, P.O. Box 68760, E. The law requires that the death certificate be executed sician and bunial-transit signed by the attending physician I be detached for use as the buna been has filled in by the funeral dir To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760,

Attending Physician:

Examine Physician/Medical Р þ Completed Be 2 Certification:

Medical

9 ∐ Unknown	O D ONKIONNI
art II. Other significant condi	ons contributing to death but not resulting in the underlying cause given in l

28a. Date of Injun

					1□ Yes	2 No	1 ☐ Yes	2 ☐ No	
			26. PI	lace of Death	(Check only o	one)			
2 🗆	ER/Outpatient	3 🗆 D	OA Other: 4	Nursing Hom	e 5□Resi	idence 6	☐Other (Spec	ify)	
Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ∐ Yes 2	28 2 □ No	3d. Describe	how injury	occurred		
/- At h	ome, farm, stree	t, factor	ry, office	28		Street and		ral Route Number,	

1 <b>EN</b> Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not be	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2□No	28f. Location (Street and Number or Rural Route Number
4 ☐ Homicide	determined	28e. Place of injury - At he building, etc. (Specif				City or Town, State)
29a. Certifier (Check only one)						e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

MEDICAL

29d. Date signed (Month, Day, Year) MAY 20, 2007 D0056658

PARKWAY

ANNAPOLIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABRAHAM 2001 Admic

31. Date filed (Month, Day, Year) MAY 2 2 2007

29b. Signature and title of certifier

27. Manner of Death

32. egistrar's Signature

5

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #29d Per Phy 6867 5/22/07 JH Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:50 a. **Physician** May 13, 2007 Hazel V. Merta /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard Elkridae Angels Alert Assisted Living | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month. Days | Hours | Min. | November 1, 7ear 919 Birthplace (State or Foreign Countridiana 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 KF 316.10.8134 87 Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b. County or Items 23s or 28s-f show other traumatic svent, the Medical Examiner must be notified at 1 Yes 2 No Director Columbia Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21046 by Funeral 6313 Beechwood Dr filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 White Specify: Specify: 3 Widowed 4 □ Divorced "natursl', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental I ant; If itsm 27 is marked o Lillie Frances Sumners Heber Jeffers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4790 Montgomery Rd. Ellicott City, Maryland 21043 nt of Health a :: If itsm 27 is Daughter Ms. Melissa Leffler Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important; If any injury or once. 05/15/2007 Baltimore, MD **Bayview Crematory** 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death enter the disease or complications the Part1. lused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1 any Langue immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 No 1 ☐ Yes 2 🔼 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Ther (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural 28d. Describe how injury courred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of 1 Liatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No м

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate less been signed by the attending physicien and Box 68760. P.0. Records. Division of Vital the

> State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 2 2

30. Name and address of p

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and

6 Could not be determined

itle of certifier



Rs,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

May 14,2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

GLEN BURNIE

IN DESHI 32 Registrar's Signature 2007

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2.50 Μ 20 Eleanor Joy Miller 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 K F Director 289-32-5370 72 Feb\_ 24, 1935 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo |Maryland| Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 303 Wakefield Drive 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller Banking and Mental Hygid permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hettler Birdia (unk) George Stanley Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
303 Wakefield Dr., Bel Air, Maryland 21014 19a. Informant's Name/Relationship (Type. Print) Fred R. Miller / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Grdn 5-22-07 Bel Air, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Metastatic Neuro Endocrine Carcinoma of Assending Colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Metastasis to Liver and Lymph Nodes and Due to (or as a consequence of): Diffrenhated Adeno Carcinoma assending Colon. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown - Colonic- cutaneous fistula. Completed Hypoalbuminemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Vital 1∐ Yes 2 **X**No safter deam.

and Director: After this cer...

and by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0018424 May -20- 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar

State

Fallston MD, 21047

Harford Road

Registrar's Signature

1908

B. Parekh MD. 31. Date filed (Month, Day, Year) NAY 2 2 2007

# Baltimore, Maryland 21215-0036

		For State	State of	of Maryla		artment of H		Mental Hy	- /	nn		5
2 - 3		Registrar  1. Decedent's Name (First, Middl	le, Last)			timeate of L	Jean	2. Date of D	Reg. No.		3. Time of Deat	th
Physic /Medi		Esther	Ε.	M	lorgan			Month May 17	, 2007	Year 7	10:35 a	a M
Exami		4a. Facility Name (If not institution Brinton Woods			ilatio	4b. City, Town, or Center	Location of Death			ounty of Dea	th	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	Sykesvii If Under 24 Hrs.	8. Date of Bi	rth	rroll	thplace (State or Fore	reian
Director		152-28-5438	1☐ M 2 <b>X</b> F	92	Yrs.	Months Days	Hours Min. Jan	uary 16		C	Jersey	3.
pu ,		Usual Residence of Decedent			No. Tour			T	,			
aryla show	٦	10a. State 10b. County  Maryland Carr			City, Town or Lo dersbur						10d. Inside City Lin 1 ☐ Yes 2)X	
the M 28a-f	Director	10e. Street and Number			acibbai	10f. Zip Code			10a Citiza	en of What C		
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ms 2; mus	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	-	pecify Yes or N		1. Race - Am	erican Indian,	-
after or Ite	P.	1 Never Married 2 Mar	nied Armed F 1 ☐ Yes If Yes, G	2 No		If Yes, specify Cuba 1 □ Yes 2XINo		o Rican, etc.)		Black, Whi Specify: Wh	*	-
ours Fxa	d by	3 KMVidowed 4 ☐ Divorced	Year or I	Dates:		TE TES ZALINO	Specify:			Specify: WI	1166	
"nat	lete	15. Deceder (Specify only highe	nt's Education est grade completed	)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of wor	king	16b. Kind	d of Business	/Industry	
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) 9th	College	(1-4or 5+)	Homem		,		0wn	Home		
Hyg other ent, I	Be C	17. Father's Name (First, Middle,	, Last)		1		18. Mother's Nan	ne (First, Middle	e, Maiden S	umame)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	James Blair Ti	pman Earl	L			Hilda	Carlser	1			
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		23a. Pay11. Enter the disease, o	r complications that	caused the de	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between	
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/Medical Examiner		resulting in death)	Due to	o (or as a conse								
LAdillilei	-	Sequentially list conditions,	b	o (or as a conse	acuonae ett:							
uted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		7 (OI 43 & COII36	squerice or).							
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ertifica ing ph	Med	IF FEMALE:										
death certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1□Live	utcome pf preg	tal death 3[	Ectopic pregnancy			23	3d. Date of de Month	elivery Day Year	
uires that the de signed by the a	Physician/Me	1 ☐ Yes 2 ☐ √No 9 ☐ Unknown	9□Unk	gnant at time of nown	rdeath 5L	Other (specify)					,	
that ned by deta		Part II. Other significant conditi	lons contributing to	death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute i	o the cause of death	?
w requires been sign should be	ed by	DIABETES	MERGIN	45		·		1	Yes 2	No 3□F	robably 4 4 thinkno	own
law re as bee 2 sho	Completed	CONGESTIO	VE HEAR	7 FAIC	uRG			24a. Wa		24b. Were a	utopsy findings availa	able
slcian: The law s certificate has t irector, page 2 s	Som.		,	, , , , , , , , , , , , , , , , , , , ,					opsy formed? 2 → No	death? 1 ☐ Ye	completion of cause	01
sician: Th certificate ector, pag	Be (	25. Was case referred to medica examiner?				Lau	26. Place of Dea	th (Check only	one)			
<u> </u>	2	1 Yes 2 No		Inpatient 2 e of Injury	ER/Outpatie		4 LL Nursing H			Other (Sp	ecify)	
dlng After funer	ion	1 ☑Natural 5 ☐ Pendi		onth, Day Year)	Injury	Worl	yat k? Yes 2 □No	28d. Describe	how injury	occurred		
Atten deatl sctor: y the	fical	3 Suicide 6 Could	not be 28e. Plac	ce of injury - At	home, farm, st	reet, factory, office		28f. Location	(Street and	Number or F	ural Route Number,	
al or all	Certification:	4 ☐ Homicide determ	buil	ding, etc. (Spe	cify)			City or To	own, State)		,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica		29a. Certifier 1 Certifyi (Check only 2 Medica	ng Physician: To th	ne best of my k	nowledge, dear	th occurred at the tin	ne, date and place	e, and due to the	e cause(s) a	and manner a	s stated.	
the H hin 24 the F	Medical	one)	and ma	inner stated.				1				
5 % Kiti	~	29b. Signature and title of certific	er			29c. License	e number		29d. Date	signed (Mon	th, Day, Year)	
		30. Name and address of person	who completed co	use of death /I+	em 23al /Tun-	Print)	0806		7/1	7/200	7	
1		JU. Hampanu auuress of persor						. / // /				
6		PATRICK TO	ener Cu	(to 11)2	1000	Libertus	Road t	douster	4 14	D 21	734	
	ate	TATRICK TU	enos Su	Registrar's Sig	1000	Liberty s	food t	Eldersh	14 N.	0 2(	784	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of State of Maryland / Department of Health and Mental Hygienes of State of Maryland

			For State Registrar	otate of Maryla	•	artment of H rtificate of I		,	giene Reg. No.	07	16562
Ü			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Voor	3. Time of Death
	Physicia /Medic		LOUISE 1	1CGHAN				MAY	Day 17 2	Year	10:60 PM
	Examin		4a. Facility Name (If not institution, give stre	eet and number)			Location of Death		4c. County	of Death	
		160	HARBOR HOSP				IMORE				
	Funeral		5. Social Security Number 6. Sex 1 □ N	2 St. F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n /, Year)	9. Birthp Coun	place (State or Foreign ntry)
e.	Director		578-03-6913 Usual Residence of Decedent	7.	92 Yrs.			May 1,	1915	GA	
	land ow at		10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sh	tor	MD Anne Arun	del Lin	thicum						1 ☐ Yes 2 ☑ No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	th wit	<b>Funeral Director</b>	314 Cheddington Rd.			21090			USA		
	ems ems	ner		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Rac	e - Americ	
2	or it		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1	1 ☐ Yes 2 ☑ No	Specify:	. ,	Specif		ite
Ś	hours tural	d by	3 ☑ Widowed 4 ☐ Divorced  15. Decadent's Educat	Year or Dates:	160 Door	dent's Usual Occup	ation		16b. Kind of B		
2	in 72 "na" r	olete	(Specify only highest grade c	ompleted)	i (Give	kind of work done of NOT use retired	during most of work	ing	TOD. KING OF B	usiness/in	Justry
7	with jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Offic	e Work			General	l Bus	iness
2	other Jent,	Be C	17. Father's Name (First, Middle, Last)		•		18. Mother's Name	(First, Middle,			
0	uld be Jenta rked ric ev	O E	Walter K. Godbee				Agnes Da	aniel			
2	2 sho and 1 Is ma auma	i	19a. Informant's Name/Relationship (Type.	Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City or Town,	State, Zip	Code)
A	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene are 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mrs. Patricia Chand								
5	ges 1 t of H if Itel or oth		20a. Method of Disposition 1 ☐ Burial 2√3€ Cremation 3 ☐ Rem		Place of Dispo cemetery, crer	sition (Name of matory or other plac	May 2	Date 1	20c. Location	· City or To	wn, State
	tmen tant: jury		4 □ Donation 5 □ Other (Specify)			e Cremati	on 200	)7	tevens		
ב ב	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra		21. Signature of Funeral Service Licensee	— M014		2. Name and Addres	'uneral Ho		cond Av		
100			23a. Parl 1. Buer the disease, or complica shock, or hear failure. List only one							, FII)	Approximate
2	Physician		Immediate Cause (Final	4.							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	HYPERTENSI Due to (or as a conse		FROSCLER	SIS DIS	EAST		2	10 years
	Examiner		Sequentially list conditions								
As	P #s	iner	Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a ronse	quence of):						
	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	nuence of					-	
5	icate be executed physician and s the burial-transit	al E		240 10 (01 40 4 001100							
	- m #	edical	d								
5	leath cert attending for use	Physician/M	IF FEMALE: 23c. Was decedent pregnant 23c.	If yes, outcome pf preg		7=t-=:			23d. Da	te of delive	ery
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mo	onth	Day Year
	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	hys	9 Unknown								
ń	res th signed be de	þ	Part II. Other significant conditions contri	-			en in Part I.	23e. Did to	_		ne cause of death?
5	requi	sted	CHRONIC OBSTRUCTI	VE PULMCHA	RY PISE	A)E		3	<u> </u>		
ב	e law has b	Completed						24a. Was a autop	sy	Were auto prior to cor death?	psy findings available mpletion of cause of
5	n: Th ficate r, pag		OF Management and the medical					1□ Yes	2 No	1 ☐ Yes	2 No
5	sicla s certi irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hos	pital: 1 Inpatient 2[	TER/Outpatien	t 3 DOA Othe	26. Place of Deather: 4 ☐ Nursing Ho			(0	
5	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe h			<i>y</i> )
2	ath. rr: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □No				
2	r Atte er dei recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Numb	er or Rura	al Route Number,
2	ital o	Cer									
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director, page 2 of the funeral director.	Medical	29a. Certifier 1	ian: To the best of my ki r: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the or red at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)
	To the To the To the Comp.	ž	29b. Signature and title of certifier			29c. Licens	e number	1	29d. Date signe		
			1 Johnson	ρ.		RE	5000		HAY	17	2007
	10		30. Name and address of person who comp	oleted cause of death (Ite	em 23a) (Type,	Print)	1 540	241		11	-
	(		FRANCOIS GRE 31. Date filed (Month, Day, Year)	GOIRE 300 32. Régistrar's Sign	nature -	H HADOUGI	C STREET, A	DALTIMON	CE, PP,	1166	<i>3</i>
	Sta Registr		MAY 2 2 20	07 Beer	D. A	PRALLS					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 563 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200°7 11:45 p M May Kalman С. Mezey, MD 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson **Blakehurst** 8. Date of Birth (Month, Day, Ye Sept 18, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Months Days Hours 97 1**X** M 2□ F 1909 Hungary 156-32-5411 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Towson Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21204 1055 W. Joppa Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11 Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Heller Malvina Adulf Mezey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1103 Harriton Rd. Baltimore, Md. 21210 Esteban Mezey, MD/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State U N KDate 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between

**Physician** /Medical **Examiner** 

Physician

/Medical

**Examiner** 

Director

Funeral

Be Completed by

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Re Completed hy within 24 hours after death

To the Funeral Director:
completely filled in by the

**ro the Hospital or Attending Physician**: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition	Metastat	2 cho	ledocho	carcino	na	18 mont
resulting in death)	Due to (or as a consequen	ce of):				
Sequentially list conditions, in the cause of the cause of the cause (Disease or injury	bDue to (or as a consequen	ce of):				1
that initiated events resulting in death) Last	C. Due to (or as a consequent	ce of):				٩
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnanc 1 ☐Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3 Ectopic pre			23d. Date of deli Month	ivery Day Year
Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying ca	use given in Part I.	23e. Did tobacc		the cause of death?
				24a. Was an autopsy performed 1∐ Yes 2 ☑	prior to death?	itopsy findings available completion of cause of 2□ No
25. Was case referred to medical			26. Place of D	eath (Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	/Outpatient 3 □ DO	Other: 4 Nursing	Home 5 Residence	6 □Other (Spec	cify)
27. Mar er of Death  1 V Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)		ic. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not determine		e, farm, street, factory,	office	28f. Location (Street City or Town, Si	and Number or Ru tate)	ural Route Number,
29a. Certifier 1 ✓ Certifying I (Check only one) 1 ✓ Medical Ex	Physician: To the best of my knowler aminer: On the basis of examination and manner stated.	edge, death occurred a n and/or investigation,	t the time, date and pla in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier		29c.	License number	29d.	Date signed (Mont	h, Day, Year)

6301

CRITICAL

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. McConnell ( 32. Registrar's Signature

Blow I. fraile

DHMH 17 Rev 1/2001

40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1620 M Physician 2007 na Charles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bayview Care Center Baltimore City If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec 26,1921 5. Social Security Number 6. Sex **Funeral** 1X M 2 □ F Dec Maryland 213-12-6649 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If item 27 is marked other then "naturel", or items 23e or 28e-f show 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Manical Examiner must be natified at 1 Yes 3 No Funeral Director Baltimore Eastwood Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21224 542 47th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify imore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>Esskay Meats</u> 12th Meat Cutter 18. Mother's Name (First, Middle, Maiden Sumame) (unk) 17. Father's Name (First, Middle, Last) Catherine Nueslein Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 542 47th Street Baltimore, Md. 21224 Agatha Nueslein (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of h
Importent: If ite
eny injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem 5-23-07 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License, Robert 1201 Dundalk Ave. Baltimore, Md. 21222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Enter the disease Immediate Cause (Final disease or condition resulting in death) Sepsis Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No ٩ 28d. Describe how injury occurred 28b. Time of completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? el or Attending Plaster death. 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

31. Date filed (Month, Day, Year) Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5505 HOPKINS Cordi 5 MO

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Physician Mattie B. Newbill 61 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL RALTIMORE N/A GOUD S'AMARITAN If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 M 2 XF Yrs Maryland 204-22-0952 76 Sep 23, 1930 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Mudical Examiner must be notified at 1 No 2 No **Baltimore** N/A Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3400 Ednor Road- Apt 105 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X o 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Specify Specify Black δ 3 XVidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Private Residence 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Ethel Stills James Stills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1245 Limit Avenue Baltimore, Maryland 21239 Jocelyn S. Stills item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If ite 1 Surial 2 Cremation 3 Removal from State 05/23/07 Owings Mills, Md. Depertment important: If any Injury or gode. Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Futaw Place Baltimore Md 21217 10 23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pulmenery Embolism ASPIRATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SMALL BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed PERIPHERAL VACCULAR DURME DISEASE COPD Exam COPONARY ARTERY that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Carcinama been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No certificete s after death.
rat Director. After this cerninc...
... in by the funeral director, p. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ۴ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1 Naturai 5 Pendina 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D 5 17 07 OUO RES 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL, BALTIMORE, SANDEEP MAGOON 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Maryla		artment of Health an	R	eg. No.2007	15568	
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Emma E. C  4a. Facility Name (If not institution, give s.  Howard County Ger	treet and number)  7. Age (In y.	6/	4b. City, Town, or Location of D		Day Year  17, 2007  4c. County of Death  1600a-1		
2	Funeral Director	200	5. Social Security Number 216-22-1636 6. Sex 216-22-1636 1	M 2 F 7. Age (In y	rs. last birthday) 77 Yrs.	If Under 1 Year If Under 24  Months Days Hours M	Hrs. 8. Date of Birth Min. (Month, Day July 6	9. Birth Con 1929	npiace (State or Foreign untry) Maryland	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	rector	10a. State 10b. County	oward 10c.	City, Town or Lo	Ellicott City		0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No	
	s 23a or	eral Di	2530 Kensington Gard		110	2104		U.S	S.Á.	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black, White		
21215-0036	d within 72 h giene. er than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired) Buyers Secretary / Bo	working	16b. Kind of Business/l	etail	
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	1 and 2 sho Health and em 27 Is ma	j	19a. Informant's Name/Relationship (Typ	e. Print) Husbar	. 1	ng Address (Street and Number of 2530 Kensington Garde	r Rural Route Number en Unit 102 Elli	r, City or Town, State, Z cott City, Maryla	(ip Code) Ind 21043	
Baltimore,	Pages 1 ament of He ant: If Item		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of matory or other place) awn Memorial Gardens	05/00/07	20c. Location - City or Marriottsvi	Town, State lie, Maryland	
Ball	permit. Page Department of Important: If any injury of once.		21 fign ture of Fune al Service License	1.1	2053.	Name and Address of Facility Slack Funeral H 3871 Old Colum	ome, P.A. bia Pike Ellicot	t City, MD 21043	3	
	Physician /Medical Examiner	ier	23. Part1. Enter the disease or complic shock, or heart failure. List only on mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	e cause on each line.	equence of):	1	ediac or respiratory arr	est,	Approximate Interval Between Onset and Death	
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O. Box	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome pf pre 1□Live birth 2□F 4□Pregnant at time o 9□Unknown	etal death 3[	⊒Ectopic pregnancy ] Other <i>(specify)</i>		23d. Date of deli Month	ivery Day Year	
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or Vital	G ≅. ₹	To Be	examiner? 1 Yes 2 No		☐ ER/Outpatier	nt 3 DOA Other: 4 Nursi	ng Home 5 ☐ Reside	ence 6 Other (Spec	cify)	
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	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in I	Medical C				h occurred at the time, date and povestigation, in my opinion, death				
	To the within 2 To the complete	M	29b. Signature and title of Centifier	~ ~	70	29c. License number 04672c		29d. Date signed (Month	h, Day, Year)	

State Registrar

Deleon 31. Date filed (Month, Day, Year)
MAY 2 2 2007 Columbia

10724 Little Petroport Pkuy,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 1:50 AM **Physician** Clarence OWERS /Medical 4b. City, Town or Location of Death 4c. County of De 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 36 Yrs. 1 № M 2 🗆 F 217-80-8817 Director Usual Residence of Decedent 10d. fnside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show 1 Pres 2 □ No Director 10g. Citizen of What Country 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 1 106 If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 1 ☐ Yes 2 ☑ No Specify Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Better College (1-4or 5+) Elementary/Secondary (0-12) Masto. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Owens is marked ပ mber, City or Town, State, Zip Code ess (Street and Number or Rural Route N 19a. Informant's Name/Relationship (Type, Print) ve. 3315 Kalti. permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any injury or other traconce. OWERS-20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Finaf MYOCARDIAL **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed LEVKEMIA Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Minknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 2 No 1 Yes certificate 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death or Attending 5 Pending 1 Matural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0062254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W BEVEDERE AVE, BARTMORE M DUZIS MD RISTINA TRUI CA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Yeer **Physician** 10:40 PM YLVIA PARKER 17 2007 /Medical 4b. City, Town, or Location of Death 4c. County of D∉ath 4a. Fecility Name (If not institution, give street and number) Examiner tr. Ba If Under 1 Year 1) 10 (4) If Under 24 Hrs. 7-HOS Geriatric DITA 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days **Funeral** Hours Months 1 M 2 TF 213-30-5513 Usual Residence of Decedent Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other then "naturel", or Itams 23e or 28e-f show other treumstic event. If a Medical Examinar must be notified at 1 Yes 2 No **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ont: If item 27 is marked other then "naturel", or Itams 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) \_0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be James Ihomas 19a. Informant's Nama/Relationship (Type, Print) Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p Norwood Department of Health a Importent: If item 27 is any injury or other tree once. avage Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) tore 22. Name and Address of Facility Joseph L. Russ Funeral Home, 2222 W. North Ave. Batto. Md. 21. Signature of Funeral Service Licensee Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CATLCINOMATOSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PRIMARY CINCHONNO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Physician/Medical Examiner attending physicien and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 ØUnknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate ! 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA r this After thi 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of Certification; 1 Natural 5 Pending investigation 2 □No 1 TYes 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 65-18-2007 D064533

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar

BABATUNDE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

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GERIATRIC CTR

BARTIMORE, MD 21215

07-03824 Angela Marie Pagano

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State of Maryland / Department of Health and Mental Hygiene

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			30. Name and	address of n	erson who	complet	ted cause of	of death (Ite	em 23a)					-1061					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 **Physician** 1:04 A<sub>M</sub> Gregory Jed Prunier 14 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Maryland Months Days Hours 1**№** M 2□F 50 220-76-3010 5/28/1956 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County show r 28a-f show notified at Y∰Yes 2 No Silver Spring Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Examiner must be 20904 USA 2716 Shanandale Drive 'natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after de al Hygiene.
other than "natural", or Item 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any hjury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none Spec. Ed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jed Prunier, Jr. Ruby June Sams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5020 Sunnyside Avenue, #206,Beltsville,MD20705 Nancy Tolbert/CALMRA Inc. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial / 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/21/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signal re of Funeral Service License 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD20781 Vchelle MO1491 239 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asystole **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cerebral Palsy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that lititated events Due to (or as a consequence of) be executed Exami Seizures sician and burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1∏ Yes 25 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 【 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0/ 00056498 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Uma Polam, 1100 Mercantile Lane, #135, Largo, MD 20724 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OVERLEA HEALTH & REHAB. CENTER  Funeral Director  5. Social Security Number  20-22-3834  Usual Residence of Decedent  10a. State  10b. County  MD  N/A  BALTIMORE CITY  7. Age (In yrs. last birthday) 88  Yrs.  88  Yrs.  BALTIMORE CITY  Months Days Hours Min.  1/16/1919  10c. City, Town or Location  BALTIMORE CITY  10a. State  10b. County  10c. City, Town or Location  BALTIMORE CITY  10d. Street and Number  5625 TRAMORE ROAD  10d. City Code 21214	County of Death  N/A  9. Birthplace (State or Foreign
GERALDINE M. POLEDNA  GERALDINE M. POLEDNA  4a. Facility Name (If not institution, give street and number)  OVERLEA HEALTH & REHAB. CENTER  Funeral Director  5. Social Security Number  6. Sex 1 Months Days Hours Min. (Month, Day, Year)  1 Vsual Residence of Decedent  GERALDINE M. POLEDNA  4b. City, Town, or Location of Death  4c.  BALTIMORE CITY  7. Age (In yrs. last birthday)  When the property of the property	2007 4:20 P.M  County of Death  N/A  9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits
Funeral Director  4a. Facility Name (If not institution, give street and number)  OVERLEA HEALTH & REHAB. CENTER  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 M 2 X F 88  Yrs.  4b. City, Town, or Location of Death  4c.  4c.  4d. April 1 More 1 Year 1 More 24 Hrs. 8. Date of Birth (Mopth, Days, Year)  1 Months Days Hours Min. 1/16/1919	N/A  9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 Months Days Hours Min. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9. Birthplace (State or Foreign Country) MARYLAND  10d. Inside City Limits
Director  Direct	MARYLAND  10d. Inside City Limits
Usual Residence of Decedent	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location  MD N/A BALTIMORE CITY  10a. Street and Number 10b. County 10c. City, Town or Location  MD N/A BALTIMORE CITY  10a. Street and Number 10b. County 20b. Citi 20b. City 20b. Citi 20b. City	
MD N/A BALTIMORE CITY  10e. Street and Number 10f. Zip Code 10g. Citi 25	1∐XYes 2∐No
10g. Citi 10g. Citi 2 10g. Street and Number 10f. Zip Code 21214	**
5625 TRAMORE ROAD 21214	tizen of What Country?
11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA  14. Race - American Indian,
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
1 Yes 2√ No Specify:  3 ★ Widowed 4 □ Divorced Year or Dates:	Specify: WHITE
3 Midowed 4 Divorced Search of Widowed 1 Divorced Search of Working Specify:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind Search of Work done during most of working life. DO NOT use retired home during most of working life.	ind of Business/Industry
(a) February Secondary (0-12) College (1-4or 5+)	
N got of the state	OWN HOME
	Juname,
The property of the property o	or Town, State, Zip Code)
Description  The Rivial Borke  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Computer of Part of Computer of Part of Computer of Part of Computer o	
JOHN H. BORLEIS, JR./NEPHEW 6708 FAIR OAKS AVE. BALTIMORE, I	ocation - City or Town, State
0 0 m h 1 Y Duriel 2 Committee 2 Demous from State	TIMORE, MD
	FUNERAL HOME, P.A.
23a, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  The physician of the cause (Final disease or condition)  The physician of the cause (Final disease or condition)	Onset and Death
/Medical resulting in death)  Due to (or as a consequence of):	0
Examiner  Sequentially list conditions.  b. Amemia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
that initiated events resulting in death) Last Due to (or as a consequence of):	
of the control of the	
edic ed by service edic ed by service ed control ed con	
Second	23d. Date of delivery
in the past 12 months?    Comparison of the past 12 months?   Comp	Month Day Year
O et the second of the second	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use given in Part II.	use contribute to the cause of death?
1 Yes 27	
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1	1 Yes 2 No
25. Was case referred to medical 26. Place of Death (Check only one)	6 □Other (Specify)
Hospital: 1   Inpatient 3   ER/Outratient 3   DOA   Other: 4   Nursing Home 5   Residence	
examiner?  o 1   Yes 2   Yes 2	
examiner?  1   September   Sep	
Course (Disease or injury that initiated events resulting in death) Last    Course (Disease or injury that initiated events resulting in death) Last   Course (Disease or injury that initiated events resulting in death) Last	nd Number or Rural Route Number, e)
t of the state of	е)
To specify  The state of the st	e) s) and manner as stated. Id place, and due to the cause(s)
To specify  The state of the st	e) s) and manner as stated. Id place, and due to the cause(s)
t of the state of	e) s) and manner as stated. Id place, and due to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 110 PM 2007 ma /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltimore atonsville lanor Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-02-1916 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 9 Hours 212-22-667 Months 1 ☐ M 2 💢 F ΜD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Hygiene. other then "natural", or itema 23a or 28e-f show ent, the Medical Examiner must be notified at Baltimore 1 res 2 No MD Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 6aa Koad Koundview Funeral Pages 1 end 2 should be filed within 72 hours after deeth Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced lack Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

His. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) omestic Mother's Name (First, Middle Maiden Su 17. Father's Name (First, Middle, Be 27 is marked or traumatic ave Jallace trank riam ပ 9a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd mD 21225 · Baltimore, if itam 27 in or other tra Koundriew 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD permit. Page Depertment o Important: If any injury or once. 07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Signature of Funeral Service Licensee

23. Signature of Funeral Service Services

24. Signature of Funeral Service Funeral Services

5151 Baltimore Nat 1 Pike, Balto, mb 21

23a. Part 1. Enterture disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately Course (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LORON ARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Examine physicien and the burial-transit To the Hospitei or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ MYPERFENSIVE CARDIOVASCULAR 1 Yes 2 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed certificate 1□ Yes 2 No Diractor: After this certific in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours efter 4 Homicide 1D Conflying Physiciam To the best of my knowledge, death occurred at the time, date and plane, and rise to the cause(s) and manner as stated 29a. Certifier cal npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05-21-2007 D 5059107 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUMNESS DRIVE 210 CENTER REISTERSTOWN Uma 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear AMES 10:52 AM MAY 20 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) RANDALLSTOWN HOSP Baltimore NOOTHWEST ITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6 Sex Months Days 150 M 2 □ F Sept 21, 1942 WV 64 234-64-4033 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2X No Reisterstown MT Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 5 Franklin Valley Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Tyes 2√ No Specify. Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Westinghouse Supervisor 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cox Delsie Floyd Rarey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21136 Franklin Valley Circle Reisterstown, MD Wife Luana S. Rarey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, Maryland 4 □ Donation 5 □ Other (Specify) Carroll Crem. Serv 5/21/07 21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road 21136 Reisterstown, MD Eline Funeral Home 23a. Part1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMON Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No performed? 2 TNo 10 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 PNo 1 Popatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 1 ☐ Yes 2 ☐ No

the burial-transi and P.O. Box 68760, attending physician as use for signed by the a law requires that Division or Vital Records, certificate has been si rector, page 2 should I or Attending Physician: funeral director. After this

Hospital

Examiner Physician/Medical Be Completed by Medical Certification: To

s after death. filled in by the 24 hours a Funeral [

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

the

filed within 72 hours after death with the l Hygiene.

s 1 and 2 should be filed wir f Health and Mental Hygien tem 27 Is marked other th

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Isany injury or other trau

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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127 State

completely

within 24 the

Registrar

27. Manner of Death 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

29a. Certifier

(Check only

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D24325 29d. Date signed (Month, Day, Year)

MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINCEA TODOK RANDALLETOWN OLD COURT ROAD HOSPITAL T2=WHTS10M

31. Date filed (Month, Day, Year) 2007





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:00 P Ruth 019 18 05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 98 Yrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Days Min. 1 □ M 2 □X 220-12-6868 29,1908 Maryland Director May Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits Hygene. other than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at Baltimore MD 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 6616 Belair Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumattc event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Beyer George Michael Raubach ဥ 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Colleen Baker-granddaughter 502 Limerick Court-Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State May 22,2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. 3 Newport Drive FVANS FINERAL CHAPTE 3 Newport Drive AD CREMATION SERVICES Forest Hill, Maryland 21050 KME 7 ondrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nknown /Medical Due to or as a consequence of **Examiner** Report Sequentially list conditions, Due to (or as a conse ue yee of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph I for use as th IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient ၉ 2 ER/Outpatient 3 DOA 27. Mann of Death eral Director: After th filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

n

P

m D

32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Borniv

(Month, Day,

60113

5601

Lich Roven

05

21239

Bluil

200

07-03703	
Charles Ratliff,	Jr.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 14, 2007 1210 hrs Medical Examiner Charles Ratliff, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's 3225 Walters Lane Apartment 201 District Heights 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** CountlyOuisiana Months Days Hours June 2, 1955 Director 51 435-86-7311 1X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a, State Yes 2 X No District Heights s 23a or 28a-f show e notified at once. Prince George's MD more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20747 USA 3225 Walters Lane #201 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 Married 1X Yes "natural", or Yes, Give Year Specify: Black 1 Yes 2 X No specify: Widowed Divorced (unk) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Important: If item 27 is marked other than injury or other traumatic event, the Medical Trucking Truck Driver Comp 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margreet Middleton Be Charles Ratliff, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 9611 Grandhaven Avenue Upper Marlboro, MD 20772 Katrina M. Thompson/daughter 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 05/19/07 Chesapeake Crematory Beltsville, MD Other Specify Donation 5 Many anomess of emation Service 21. Signature of Funeral Service Lios P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical nding physician se as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.0. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? nerformed? ✓ Yes 2 1 🗸 ertificate 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: director, Division of Vital Be Other 4 Hospital: DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 FR/Outpatient 3 this ( 1 Yes After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: ✓ Natural Yes 2 No Pending within 24 hours after death. To the Funeral Director: the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 15, 2007 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registra

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 11 7

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	Certificate of Death	Reg	g. No.	10070
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Physician /Medical	Nancy E. Rotondo	2	18 5001	450 AW
Examiner	4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Lot	cation of Death	4c. County of Deeth	
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Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1 M X F 83 Yrs.  1 M M X F 83 Yrs.	Month, Day, V	(eer) 9. Birthp	elece (State or Foreign
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fand fand	10a. Stete 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
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So at the second	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes. Give 1 ☐ Yes 2 💆 No Specify:		Specify: Whit	
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Maryland d 2 should be fill th and Mantal H 7 is marked oth traumatic even	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rure	el Route Number, (	City or Town, State, Zip	Code)
() (= 0 -	Kimberly Bogris (Daughter) 201 Wagner Rd Bel Afr,	MD 2101	5	
Baltimore, semit. Pegas 1 as Department of the mportant: if item inty injury or other ance.	20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	0c. Location - City or To	wn, State
Page Page nent: if ury o	4 □ Donation 5 □ Other (Specify) Bel Air Memorial Gardens 5-	-21-2007	Bel Air,	Maryland
Baltimo permit. Pag Department Important: It any Injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Sch	imunek Fu	uneral Home	of Bel Air
	Buca allelle Inc. 610 W. MacPhai			
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6876C tificata bar ng physicia as the bur	resulting in death) Last			
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or Ar after Directiff	4 Homicide determined building, etc. (Specify)	City or Town,		
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Divisio  To the Hospital or Attendif within 24 hours after death. To the Funeral Director: A complately filled in by the ta	(Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurr and manner steted.	red at the time, dat	te and place, and due to	the cause(s)
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Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If ficen 27 is marked other than "natural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once.

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Mec	examiner John	Emerson Ridgely	

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Registrar

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07-03689 Edward Ridgell, III

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State of Maryland / Department of Health and Mental Hygiene	96.
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Funeral		5. Social Security		6. Sex		7. Age (In	yrs. last bi	rthday)		r 1 Year s Days	If Under Hours	24Hrs. Min.	1	•		Foreign	place (State or	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: or other traumatic event, the Medical Examiner must be notified at once.	۱-	Susan J				ster)											land 212	207
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Ing Ph	i.	27. Manner of Dea		<u>1</u>	28a. Date (Mgnti	of Injury n, Day Year) , 2007		. Time of I	njury	28c. Injury			28d. Describe Subject Sta					
ion trend leath. tor:	atio	1 Natural 2 Accident		ding	May 14	, 2007	00	00 hrs		1 Ye	es 2 🗸	No						
Division of Vital Records, pital or Attending Physician: The law requirours after death. reral Director: After this certificate has been stilled in by the funeral director, page 2 should la	Certification	3 🗸 Suicide		ld not be				farm, stree	et, factory	, office bu	ilding, etc		or Town,	State)			al Route Number	r, City
Spital Spital Hours Hiller	Ç	4 Homicide 28a Certifier		ermined		Single							8606 Clarne					
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only 1 one) 2		aminer:O	n the basis	of examina							due to the cau the time, date					
To wit	Mec	29b Signature and	d title of certif		nd manner :	stated.			29	c. License	number			29d. Da	ate sign	ed (Mon	th, Day, Year)	
4		100	Ad An	loss	ul	)				O.C.N	1.E.			May	14, 20	07		
/		39. Name and add	iress of perso	n who con	npleted cau	se of death	ı (Item 23a	1)										
2		Laron Lock			nt Medica	:4		11 Penn	Street	, Baltim	ore, MI	D 2120	)1					
Sta Regist	ate rar		nth, Day, Year			egistrar's S		of the same	Branch Control									
			TIRE ! . 7 /.	14 / 13/	1 1	A. 18.		- 4										

07-03670 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ray Richardson 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 13, 2007 1155 hrs Medical Examiner RICHARDSO 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Baltimore Bon Secours Hospital 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Director Country) 316 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No items 23a or 28a-f show ust be notified at once. imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number Funeral 11. Marital Status 12. Was Decedent Ever in Was Decedent of Hispanic Origin? (Specify Yes or 14. Race - American Indian, Black, Department of Health and Mental Hygrene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 1 X Yes If Yes, Give Year Specify: Yes 2 X No specify: Widowed Divorced ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JEROME HAWKINS 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery /Date -12--07 crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify. 22. Name and Address of Fac nature of Funeral Service Licenses HOME FUNERAL BALTO, MD Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Between Onset and /Medical Death a. Atherosclerotic cardiovascular disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Records, P.O. Box 68760, Physician/Medical X AMENDED #20b perFH #23a PII 27 perME s X UNPENDED attending physician or use as the burial -23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Chronic alcoholism Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 2 No 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be examiner? Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Other: Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Yes 2 No Pending completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 14, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Rawls **Physician** Jean Rena May 15, 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8028 North Boundary Road Dundalk Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 F Director 219-32-5350 72 April 18,1935 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ XSo Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 United States 8028 North Boundary Road

Status

Status

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 27 No If Yes, Give Year or Dates: Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Short Order Cook Diner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Horsey Rosalia Taylor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Barry C. Rawls (Husband) 8028 North Boundary Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 5/19/2007 21. Signature of Funeral Service Ligen/see 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 21 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Registrar

State

29b. Signature and title of certifier

Deburan L

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007 2

and manner stated

HOOS 5992

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

6730 Hulabird Ave Baltimore

82 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 Day 16 **Physician** 08:57p <sup>M</sup> Louis T. Rossi 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 643 S. Decker Avenue If Under 1 Year If Under 24 Hrs. Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 □ F Director 220-18-6517 11/26/1926 80 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1X Yes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 643 S. Decker Avenue 21224 A. 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 X Never Married 2 Married 2 X No 1 ☐ Yes 2 🛣 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Louigi Rossi <u>Nunzia D'Alesandro</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 11645 Mecklin Creek Road, Berlin, MD 21811 <u>Melvin Ross, Nephew</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 05/21/2007 4 □ Donation 5 □ Other (Specify) Hilltop Svc. Corp. Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. alot of sibnogell 5305 Harford Rd. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial infaratron

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

		Due to (or as a consequence of):			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as a consequence of):			
dical Exa	that initiated events ' resulting in death) Last	C. Due to (or as a consequence of):  d			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ed by Pl	Part II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unknown
Complet				24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		26. Place of	Death (Check only one)	
To.	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	nt 3 DOA Other: 4 Nursir	ng Home 5 Residence 6	☐Other (Specify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
Medical Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		reet, factory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number, )
dical (		nysician: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.			
Me	29b. Signature and title of certifier		29c. License number	29d. Date	e signed (Month, Day, Year)

RES-000

BALTIMORE, MD

17,2007

Mau

State Registrar TARA

31. Date filed (Menta Day, 2 ear) 2007

MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERTE

To the Hospital within 24 hours a To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 17, 2007 ear 4:35 a **Physician** Bertha Roark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 7421 Rockridge Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Mar 11, 1934 Birthplace (State or Foreign Country)
 Arkansas 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F 73 278-30-4322 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 23a or 28a-f show 1 ☐Yes 2 ☐ No Raltimore N/A notified Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 'natural", or items 23a or dical Examiner must be 21208 7421 Rockridge Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Agency 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Health Care Worker 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Annie Lee McCalf Alfred Martin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7421 Rockridge Road Baltimore, Maryland 21208 permit. Pages 1 and 2 to Department of Health ar Important: If item 27 Is any Injury or other trau Willie Roark Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 05/22/07 Woodlawn Cemetery & Chapel 4 Dopation 5 Other (Specify) 21. Signature of Funerath Source Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) bneastcancinon Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the a 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA iuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending 1 TYes investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 29b. Signati who completed cause of death (Item 23a) (Type, Print)

A. Levine 6569 North Charles St.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2007

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

ENORA

#### 07-03845 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cornell L. Smith State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day May 20, 2007 Medical Examiner CURNELL L. Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 83 N and Guilford Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Director 30 1967 Country) 1 V M 2 F 39 218-78-9865 Usual Residence of Decedent 10c. City, Town or Location 10a. State narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. MD BALLIMORE Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21209 USA 4900 GREENSDRIN Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 1 Yes Specify: BIK Divorced If Yes, Give Year 1 Yes 2 No specify: Widowed 4 ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed SERVILE Elementary/Secondary (0-12) College (1-4 or 5+) EXCELLENCE INC 1201ECT 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LIZABETA Crawford CURNELL 19a. Informant's Name/Relationship (Type, Print) ELIZABETA Smith (mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 05/25/07 Woodlawn CEMETERLY Other Specify Randullstown 8728 LI BERTY Rd rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician ilure. List only one cause on each line /Medical a Multiple Injuries Immediate Cause (Final disease ⊂xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit AMENDED UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy

3. Time of Death

2005 hrs

NID

10d. Inside City Limits

1 V Yes 2 No

Approximate Interval

Between Onset and

Year

2 No

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3534 Carriage Hill Cir. apt. 104 Randall Ctown. 20c. Location - City or Town, State BALTIMORE 22. Name and Address of Facility Valusin C. GREEN EF unotal Services The law requires that the death certificate be executed Physician/Medical ned by the attending physician detached for use as the burial -Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Δ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? ✔ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 After this ို 1 🗸 Yes No 28a. Date of Injury (Month, Day Year) May 20, 2007 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Driver of motorcycle in vehicle- fixed object 1953 hrs Natural Yes 2 V No Pending Funeral Director: the collision 2 🗸 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) I-83 North and Guilford Avenue, Baltimore, MD (Specify) Interstate/Express Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 21, 2007 O.C.M.E. me and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Pamela E. Southall, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Modus Day, Year) 200 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 13:50 PM Thomas Sweeney MAY 17 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A (HOSP 27AL 21229 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. WD, AGNES 8. Date of Birth (Month, Day, Year) April 17,1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F 81 219-22-7130 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 XNo Director Baltimore Catonsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a **USA** 21228 715 Maiden Choice Lane PV 502 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No 1944 If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) Telephone Company Technician 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Murphy Frank Sweeney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 is any injury or other tra once. 715 Maiden Choice Lane, PV 502 Catonsville, MD 21228 Jane Sweeney, Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Date 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 05/21/07 Woodlawn, Maryland 21. Signature of Funeral Service Lice so Thomas Gregor 22 Name and Address of Facility
MacNabb Funeral Home, P.A. <u>301 Frederick Road Cátonsville, Maryland 21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BLEEDING LASTROINTESTINAL /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown FARURE, CHRONER KIDNEY DAYEASE page 2 should Be Completed DEABETES 24a. Was an Were autopsy findings available prior to completion of cause of DISEASE 25. Was case referred to medical examiner? performed? res 2 No death? 1 ∐ Yes 2 No DECEASE 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 ☐ Suicide 6 ☐ Could not be within 24 hours after dea To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier

1401

TANA

State Registrar 31. Date filed (Month, Day, Year)

21227

29d. Date signed (Month, Day, Year) 17,2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTEMORE NOD 21229-ADIREDDI SE AGNES ISTORP 34AL

MAY

32 Registrar's Signature

Division of Vital Records, P.O. Box 687600 To the Hospitel or Attending Phwithin 24 hours efter death.

To the Funeral Director: After the completely filled in by the funeral

3altimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nguyen,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thao

10

Thao Nguyen, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

Medical Doctor

32. Registrar's Signature

29c. License number

Res - 000

29d. Date signed (Month, Day, Year)

May 19, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Departm	cate of Death		Reg. No. 2007	16587			
7	Physicia	ın	1. Decedent's Name (First, Middle, Last)  Fred Shifflett		2. Date of Dea Month May	Day Year 2007	3. Time of Death  3:30 p <sup>M</sup>			
	/Medic	6.1	4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death	riay	4c. County of Deat				
			.020 12101	0 Date of Birth	Carroll	halana (Chata as Francisco				
62.	Funeral Director		1 □ 35M 2 □ F 76 Yrs. Mor	8. Date of Birth (Month, Day 03/03/1	004	hplace (State or Foreign untry) rginia				
	fand ow It	ŀ	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits				
	Mary a-f sh ffied a	tor	MD Carroll La	andsdowne			1 □Yes 2 No			
	ith the	Director	10e. Street and Number 10	f. Zip Code	1	10g. Citizen of What Co				
	s 23a	ral	243 Second Avenue  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was D	21227	onify Von or No	United S				
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 2 and	by Funeral	1 □ Never Married 2□ Married 1 X Yes 2□ No	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto es 2X No Specify:	Rican, etc.)	Black, White				
21215-0036	n 72 ho '"natur ledical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind life. DO N	ding	16b. Kind of Business/	Industry				
212	filed withi Hygiene. Ither thar	mo	Elementary/Secondary (0-12) College (1-4or 5+)  Carr	penter		Construc	tion			
	2 should be filed w n and Mental Hygie r Is marked other tr raumatic event, th	Be	17. Father's Name (First, Middle, Last) William Shifflett			Maiden Surname)				
Maryland	hould d Men narke natic	၉			Mma Davis  Route Number, City or Town, State, Zip Code)					
Ma	and 2 s ealth an n 27 ls n ner traun		, ,	mmel Drive, Syk		-				
ore,	es 1 and 2 of Health fitem 27 r other tr		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cremator,	(Name of y or other place)	Date	20c. Location - City or	Town, State			
Baltimore,	. Page tment tant: It jury o		4 □ Donation 5 □ Other (Specify) Bayview Cre	_		Baltimore,				
Ball	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		malet 29 4107	ne and Address of Facility Hul Wilkens Avenue	e Balti	more, MD	21229			
e te			23a. Part1. Enter the disease, o compleations that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory and	rest,	Approximate Interval Between Onset and Death			
8	Physician /Medical	9 1	Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	TRUNUNA	201	54				
	Examiner		(A)							
	p #	iner	Sequentially list conditions, it any, leading to minediate cause. Enter Underlying Cause (Disease or Injury that initiated events							
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C							
68760,	e be e rsician e buria	edical E	d							
	#a oo a	/ledi	IF FEMALE.	w will						
P.O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M		pic pregnancy er (specify)		23d. Date of de Month	livery Day Year			
	s that ined by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did to	obacco use contribute to	o the cause of death?			
ord	equire	ted k	<u> </u>		1 U Y	Yes 2 No 3 P				
Division or Vital Records,	The law ate has b page 2 sh	Completed			24a. Was a autop perfor	rmed?   death?	utopsy findings available completion of cause of 2 No			
Vita	Physician: this certific	Be	25. Was case referred to medical examiner?  Hospital: Hospital: A Classical of CERP (Authorized 2015)	26. Place of Dea						
J Or	Phy rthis	n: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 ER/Outpatient 3 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	DOA 4 Nursing H		dence 6 Other (Spenow injury occurred	еспу)			
sio	Attending r death. ector: After by the fune	catio	2 Accident investigation		29f Location /S	Street and Number or R	ural Pouto Number			
Divi	affor Ataffer d affer d I Direct d in by	Certification:	3 Suicide determined determined 28e. Place of injury - At home, farm, street, f building, etc. (Specify)	actory, office	City or Tow	vn, State)	arar Frodie Warriber,			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: v completely filled in by the f	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigant manner stated.	urred at the time, date and place gation, in my opinion, death occu	, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)			
_	To the within To the compl	Me	29b. Signature and title of certifler	29c. License number		29d. Date signed (Mon	th, Day, Year)			
	. , \		- Thange	023137		V-2/-	07			
1	2%		29b. Signature and title of certifler  30. Name and address of person who completed cause of death (Item 23a) (Type, Print How Konth Title 16.6)  31. Date filed (Month, Day, Year)  MAY 2 2 2007	927, ANNA	rous	, Korr	2122)			
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 2 2 2007	2						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:15 AM MAY 2007 Edward Charles Straley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Home Baltimore
If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 1 (X) M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-34-6870 Yrs. Director 70 11/15/1936 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at Director 1X Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3010 Mary Avenue 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify. δ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-Employed Auto Parts Maryland permit. Pages 1 and 2 should be fitt Department of Health and Mental Hy Important: if Itam 27 is marked oth any liury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ <u>Kenneth C. Straley</u> Gertrude E. Rang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Conneely, Sister 9002 Chateaguey Court, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 05/22/2007 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Myardia & Botes 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER BLADDER **Physician** MONTHS /Medical Due to (or as a consequence of):

ADENO CARCINOMA OF Examiner LEFT PELVIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical signed by the attending 5 be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably cate has been signification can be page 2 should t 1 ☐ Yes 2 ☐ No 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the heat of my knowledge death occurred at the time, date and place, and due to the date of and mainter at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ofor Awsel, mo DO061789 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOPRAINE OFORI AWUAH, GLOS PHILADELPHIA PD, STE 208, BALTIMORE, MO 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 17<sup>Day</sup> **Physician** Francis Xavier Shiber 2007 7:22 РМ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Hospital Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6 Sex 7. Age (In vrs. last birthdav) **Funeral** Days Hours Min 1472071928 1**⊠**M 2□F 141-20-5880 78 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Maryland N/A 1 Y Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3025 Echodale Avenue 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 3altimore, Maryland 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Disabled Dependent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Shiber Mary Gallagaer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerome Shiber - Brother 218 3rd Street Ridgefield, NJ 07660 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 05/22/2007 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 / Comes 23a. Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATHEROSCIEROTIC CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-trar and Due to (or as a consequence of): Box 68760. nding physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has this certificate 1∐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NA/Outpatient 3 DOA 1 Yes 2 100 2 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) funeral ( 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at it. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062735 mD

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

BLVD. BALTIMORE, MD

5601 LOCH RAVEN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APARNA JONNAL

07-03812	
Wilson Murray Shook	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 16	0	9	- moreover
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		1- For State Registrar	Cert	ificate of	Deat	h			Reg. N	No.		
Physicia ledical Examir	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year										
		4a. Facility Name (if not institution, giv Deep Leak Lane	e street and number)			fown, or Le chaels	ocation of D	eath	4c. County of Do Talbot	eath		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM. Months Days Hours Min. May 7, 19								Ec	Birthplace (State or reigDistrict of CountOolumbia	
Maryland 28a-f show any d at once.		Usual Residence of Decedent  10a. State 10b. County  Illinois Cook		Town or Locat .nnetka							10d. Inside City Limits	
the Marylar a or 28a-f s tified at on	Director	10e. Street and Number 215 Woodlawn Av	enue		10f. Zip	Code	60093	3	10g.	10g. Citizen of What Country? USA		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	by Funeral		1 Yes 2 No If Yes, Give Yeer or Dates:	1f Y	res, specit res 2	y Cuban,	Mexican, Pu	? ( Specify Yes uerto Rican, etc	:.)	White, et	White	
	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	during m	nost of wo	king life, [	DO NOT use	d of work done e retired) esident		ib. Kind of Busine			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hor ment of Health and Mental Hygiene. Irant: If item 27 is marked other than "ma or other traumatic event, the Medical Exa	Be Com	17. Father's Name (First, Middle, Last	5+   ook			18	18. Mother's Name (First, Middle, I Ruth Doence			den Surname)		
MD 21 d 2 should Ith and Me n 27 is man	٩	19a. Informant's Name/Relationship (7 Nancy Shook	Wife	21	5 Wo	odlaw	n Ave			r, City or Town, S Lka, IL		
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specify	Removal from State Wi	lace of Dispos rematory or ot 110W I	her place Jawn	)		Date 5/24/20	07	Vernon	ty or Town, State  Hills, IL	
Balt permit. Depart Import injury		21. Signalur of Funeral Service Licer	Henss	36 36	Name and ITGEE 31 F	Address of Hens alls	r Facility SS-Sei Road,	tz Fune Baltin	eral nore,	Home, I Maryla		
Physician /Medical Examiner		23a. Part I. Enter the disease, or compfailure. List only one cause on eximmediate Cause (Final disease or condition resulting in death)	plications that caused the death. ach line.  Drowning  Due to (or as a consequence of)		tne mode	or <b>ay</b> ing, s	uch as card	liac or respirato	ry arrest,	snock, or neart	Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions.										
760, crate be executed physician and the burial - transit		events resulting in death) Last  d.  UNPENDED										
8 m m m		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  23d. Date of Month  2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of 5 Other (Specify)  1 Unknown								23d. Date of del Month	ivery Day Year	
i, P.O. I											e to the cause of death?  Probably 4  Unknown	
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use.	Completed by	<del></del>					<del></del>	_  _	Was an autopsy performe Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 No	
artification, p	Be C	25. Was case referred to medical						neck only one)				
Vit.		1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 In	ER/Outpatien	t 3	OA C	other N	lursing Home	5 Res	sidence 6 🗸 C	ther: Scene	
ion of itending P leath. tor: After the funera	ation:	27. Manner of Death  1 Natural 5 Pending  2 ✓ Accident Investigat	FOUND:	28b. Time of FOUND: 0900 hrs	Injury		at Work? es 2 ✔ No	Subject		vinjury occurred verturned in	a ditch	
Division pital or Attendi ours after death. eral Director: A	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury - At ho		et, factory	, office bu	ilding, etc.			et and Number o e) , St Michaels ,	r Rural Route Number, City MD	
fo the Hos vithin 24 hy fo the Fun completely	Medical (		ian: To the best of my knowledg r:On the basis of examination an and manner stated.									
	Ž	29b. Signature and title of certifler	et.		29	o.C.N				9d. Date signed May 20, 2007	(Month, Day, Year)	
24		30. Name and address of person who Zabiullah Ali, M.D. Assi	completed cause of death (Item stant Medical Examiner		nn Stree	et, Baltir	more, MD	21201				
St Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signatur	· Ans	MELD							

07-03639 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carroll D Simpson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 12, 2007 **Medical Examiner** 0941 hrs D. Simpson Carroll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 727 Druid Park Lake Drive Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Foreign Director Months Days Min Country) **XX**M 2 F 76 216-24-3168 /6/1930 MD. Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X XYes 2 Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "natural", or items 23s or 28s-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. MD N/ABaltimore Director 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be notified at 727 Druid Park Lake Drive 21217U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 XXNever Married 2 White, etc. Married 1 X Yes 2X No specify. Widowed Divorce Yes Give Year Specify: Black ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Musician Bank 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Simpson Simpson Emerson Helen 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Simpson Highland Ave., Morristown, N.J. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XX remation 3 Donation 5 Other Specify Garrison Forest 5/22/2007 Owings Mills. 21. Signature of Funeral Service License <sup>22</sup> Name and Address of Facility Rest Funeral Service, P. 1300 Eutaw Place, Baltimore, Md. 21 23a. Part I. Enter the disease, or complications that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure List only one cause on each line Between Onset and /Medical Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED this certificate has been signed by the attending physician. I director, page 2 should be detached for use as the burial -AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month 2 Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 ✔ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene ို 1 Yes

Division of Vital Records, P.O. Box 68760,

Certification:

2

3

Medical

30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)

Pending

Investigation

Could not be

27. Manner of Death

Accident

Suicide

Homicide

1 V Natural

29a. Certifier 1 (Check only one)

29b. Signatu

111 Penn Street, Baltimore, MD 21201 egistrar's Signatur

28a. Date of Injury (Month, Day, Year)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

28c. Injury at Work?

Yes 2 No

28d. Describe how injury occurred

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

May 12, 2007

29d. Date signed (Month, Day, Year)

Registrar

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 State Amend #18, perFH, G867, 5/24/07 TT** Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** :20 le, 2000 MA erton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** +, M 3/2 MAYMIL Wed-LAI CONTRA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, October 1) Birthplace (State or Foreign Country) Social Security Number 6. Se: Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 031-30-1299 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Funeral Director Howar Olumbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4901 21045 . Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by ac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working the DOMPT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ean Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Number or Rural Route Number, City or, own, State, Zip Code) 19a. Informant's Name/Relationship umbia, MD 21045
20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington 2007 ce Licent 21. Signature of Furtaral Serv Services Baltimore, mD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ospica ter /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed o the Funeral Director: After this certificate has been signed by the attending physician and ompletely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 2 40 210 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific completed cause of death (Item 23a) (Type, Print) 30. Name and address of 2 - Cic ŧ

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 26 **Physician** 07 romosen \*\*/Medical 4a. Facility Name (If not institution, give stree and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 Decutry Hospital 6. Sex 7. Se (In yrs. last birthday) 1 M 2 F 66 Yrs. Baltrimore, der 1 Year | If Under 24 Hrs. Mr MINEYS ITT 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 234-62-9118 Months Days Hours Min. MAY 26 1940 FLATWOODS Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at ARUNDEL PASADENA ANNE 1 ☐ Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 USA 21122 213TH 671 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) RESTAURANT Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) MITRESS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALLIE LORENA JOHNSON COWGER ပ္ WADE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AUE. 15T FLOOR 4120 HAGUE WADE BALTIMONE, MO. 2/225 THOMPSON 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once, 1 Burial 2 □ Cremation 3 □ Removal from State FRAMETOWN, WV MODLE RUN CEMETERY MAY 21,07 4 □ Donation 5 □ Other (Specify) EUGNIFUNERAL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8800 HANFORD MARYLAND 21234 PARKUELLE renner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) ENDS1468 Sequentially list conditions, if any leading cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 1 ☐ Yes 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

/Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician ō this To the mospinal within 24 hours after death.

To the Funeral Director: After

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

show

6

natural",

item 27

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifie

D 40166

s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Phesson

32. Registrar's Signature

State Registrar

Medical

31. Date filed (Most)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** May 19, VIRGINIA THORNTON 2007 3:20 p ELSIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golumbia

If Under 1 Year | If Under 24 Hrs. Howard County General Hospital Howard Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days 1 □ M 2 🗓 F Yrs. Director 86 09/20/1920 Virginia 229-42-8182 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2X No Directo Elkridge Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7734 Washington Blvd., Lot 17 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 🛛 No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Technician Caled Products 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Joseph Clevenger Linnie Clevenger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Frances Moore - Daughter 7734 Washington Blvd., Lot 17, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/23/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. 23a. Part1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Chronic Atrial Fibrillation Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Renal Insufficiency Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical Bacteremia the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 XUnknown Anemia; Respiratory Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? page 2 1□ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2X No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 5 ☐ Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely within 24 To the F and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056948 ATTENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 James Ngumela Tansinda, MD 300 Armory Place, Ste. 3H, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Registrar

State

1041

31. Date filed (Month, Day, Year)

MAY 2, 2, 2007

30. Name and address of person who completed cause of death (Item 23

ERNESTINE WRIGHT, M.D.

32. Registrar's Signature

Aprelle s

2300 DULANEY VALLEY ROAD

21093

MD

TIMONIUM

CONSTANCE

þ Completed Be Certification: To

Medical

State Registrar 30. Name and address of person

14

Jetsy

31. Date filed (Month, Day,

Sequentially list conditions, if any, leading to himsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect  Due to (or as a consect  d.	,							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopic			23d. Date of delivery Month Day Year				
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown				
				24a. Was an autopsy performed 1□ Yes					
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)					
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3□	Home 5 desidence	5 Sesidence 6 □Other (Specify)					
27. Manner of Death  1 Statural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred				
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, fact		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knuminer: On the basis of examinated and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				
29b. Signature and title of certifier	1 Fay M	ND E	29c. License number D33220	29d.	Date signed (Month, Day, Year)				

1:30 P.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

11 MUS

Baltimore MD 21211

1XX es 2 □ No

Maryland

USA

DHMH 17 Rev 1/2001

FALLS Rd

who completed cause of geath (Item 23a) (Type, Print)

32 Registrar's Signature

3

730

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Physician 2007 04:43 Mm S. Wilson MAY James /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALtimore Rosedale Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑** M 2□ F 89 217-12-1051 May 7, 1918 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ▼Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 1513 Delvale Ave. 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 Is marked or any injury or other traumatic eve ပ Violet Keckner Melvin W. Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Delvale Ave., Baltimore, MD William A. Wilson Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints' Cemetery 5/19/07 Reisterstown, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD Eline Funeral Home Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Broncho Aspiration and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria pe Physician/Medical

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown

4☐Pregnant at time of death 9∏Unknown

3 □Ectopic pregnancy 5 ☐ Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

2 No 3 Probably

Day

Year

4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Insufficiency, A-Fib, Hypertension Dementia Hypothyroidism

24a. Was an autopsy performed? Yes 2 No 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 2×100 1 ☐ Yes

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 2 ☐ Accident

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

1 Tes

29a. Certifier

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature a

29c. License number MD. (Resident Physician)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ted cause of death (Item 23a) (Type, Print)

Square Drive Baltimore, Md 000 Franklin 32. Registrar's Signature 31. Date filed (Me)

State Registrar

ed by the a

within 24 hours aller death.

To the Funeral Director: After of completely filled by the funeral

or Attending

thin 24 hours at

Completed

Certification: To

Medical

Division or Vital Records,

James

DHMH 17 Rev 1/2001



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 706 Russell William Woodger Mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore 5000 Samani Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/10/1917 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 89 110-05-3652 New Jersey Director Usual Residence of Decedent 10c. City, Town or Location 10a State Show 10b. County 10d. Inside City Limits must be notified at PA Northern Cambria Cambria 1 Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2809 Bigler Ave. 15714 USA "natural", or items 23a death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$13.00 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baker Supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Woodger Ethel Vivian ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 5 7 1 4 19a. Informant's Name/Relationship (Type. Print) Eldona Woodger- wife 2809 Bigler Ave. Northern Cambria, PA 20b. Place of Disposition (Name of MAY 20 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of P Important: if ite any injury or ot once. Evans Funeral 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chapel-4 Donation 5 ☐ Other (Specify) 2007 Bel Air Forest Hill, MD . Signatur Afruneral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD MD 21234 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in a children in a cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Yelen resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Jonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has performed 1□ Yes 2☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2⊡No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ۴ 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28h Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

2007

5001 32. Registrar's Signature

Luch

cause of death (Item 23a) (Type, Print) Raven Bonlevand Bultmore, Mayland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] Amend #28a-b,28d-e, perME, g808, 6/12/00/17 [ Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Wilson Betty L. 19 2007 7:08A May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Havre de Harford Memorial Hospital de Grace par If Under 24 Hrs. Harford If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Apr. 8, 1934 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 1 □ M 2√2 F 256-44-8948 73 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Tyes 2 No Cecil Md. Port Deposit Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21904 5 Denise Street U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl Flementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home unknown 18. Mother's Name (First, Middle, Maiden Surname) (unk) 17. Father's Name (First, Middle, Last) Be and Mental le marked William Kyle Blevins Faye ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 325 Port Deposit, Maryland 21904 f Health Arlen H. Wilson (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 5-22-2007 Baltimore, Maryland permit. Pege Depertment of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Shen 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine of Vital Records, P.O. Box 68760,怎 that initiated events resulting in death) Last Physician/Medical ovise Wilsor IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 08 Day Year) unkniury 100, 2007 12:10 M 1 Natural 5 Pending subject fell To the rospins effer death within 24 hours effer death.

To the Funerel Director: Aft Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State 501 S. Union Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Harford Memorial Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) in marrier as status. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner stated.

Ittle Lentrier 25 MAN VILVA D. Detections number 29d. Date signed (Month, Day, Year) (Check only one) BERNARD YUKNA MD, DEPUTY LICENSFILLINGER EXAMINER 29b. Signatur and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 Rovo ution 31. Date filed (Month, Day, Year) 32. Registrar's Signature State fresh. MAY 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 3:00 PM 0) nur 2007 May 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Baltimore The Johns Hopkins Bayview Hospital timore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours **X**XM 2□ F Director 170-36-4860 60 3,1946 Pennsylvania Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo Director Maryland Dundalk Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 1941 Holborn Road 21222 filed within 72 hours after death v Hygiene. United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1965-71 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 1 Year Auto Worker General Motors Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental John S. Woytek Catherine Diveley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Brooks (Daughter) 405 Virginia Ave. Essex, Maryland Department of Heali Important: If Item 2 any injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation /5 ☐ Other (Specify) St. Gregory Church Cem. 5/21/2007 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of uneral Service License 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmona Immediate Cause (Fin Chronic Obstructive **Physician** 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alwholic Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Empyema bunial-trar Due to (or as a consequence of) attending physician for use as the buna 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the sid be detached to o. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate 1∐ Yes 2 0 No Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 10 uneral 27 Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -MO KES 0001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Medical Ctr. GJOLAJ JOSEPH MD 4940 Eastern Ave. Baltimore, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day CAROLYN E. YORKMAN 5:50p MAY 7 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours 72 217-34-9587 10/19/1934 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State BALTIMORE 1 ☐ Yes 2 XNo MD TOWSON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1002 SAYWARD AVENUE 21234 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 Married 1 ☐ Yes 2X No Specify. BLACK Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DISABLED DISABLED 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARRIE E. LIGHTFOOT MORRIS K. YORKMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1002 SAYWARD AVENUE, TOWSON, MD 21234 WENDA ROYSTER / NIECE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/07 4 ☐ Donation 5 ☐ Other (Specify) CALVARY CEM. BROOKLYN, AA CO, MD 22. Name and Address of Facility 21. Signature of Funeral Service License HOWELL FUNERAL HOME 21207 LIBERTY HEIGHTS 4600 AVE, BALTIMORE, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTARC Myocardia Due to (or a a consequence of): Date to (or se a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

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To the Funeral Director: Aft

To the funeral Director: Aft

or Attending Physician:

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Certification:

physician the burial

P.O. Box 68760

or Vital Records,

Division

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

other traumatic event, the Medical

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Important: If it
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

autopsy performed? res 2 X No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes

25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 ☐ Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier 30. Name and address (person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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535 (90Sne Registrar's Signature 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Maria Teresa Yong 5:30 a. May 16, 2007 /Medical 4c. County of Death Howard 4b. City, Town, or Location of Death Columbia 4a. Facilify Name (If not institution, give street and number) 5750 Flagflower Place Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 26 ar) | 1948 Birthplace (State or Foreign Country)
 Peru 7. Age (In yrs. last birthday) 5. Social Security Number 216-53-3786 **Funeral** 1 □ M 2 KF Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Columbia Maryland Howard 1 ☐ Yes 2 No notified Director 10g. Citizen of What Country? 10e. Street and Number 5750 Flagflower Place 10f. Zip Code 21045 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be I Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secon 2ary (0-12) College (1-4or 5+) Self employed Self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Santaigo Yong Can Justina Martinez Santos 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5750 Flagflower Place Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type. Print) Mr. Dante Neyra Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD (Vation Value)
MD (Vation Value) Date 20c. Location - City or Town, State 20a. Method of Disposition 05/21/07 1 Burial 2 Cremation 3 Removal from State MD 121 Part We morial Part 22. Name and Address of Facility Slack Funeral Home, P.A 2071 Old Columbia Pike I 4 □ Donation 5 □ Other (Specify) laurel MD of Funeral Service Lice ee 3871 Old Columbia Pike Ellicott City, MD 21043 Ma0535 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Cholangio Carcino Ma **Physician** monuh: /Medical Examiner Sequentially list conditions any course to improve the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy In the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by the 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 2 **W** No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home ဥ 5 Residence 6 □Other (Specify) 27. Man r of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 V Natural Iniury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifier 29c. License number Suite 305 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11120 New Nampshire Ava Silver Spring M.D. 20904 with ichael 32 Regietrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

22

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	party.	-		
State of Maryland / Department of Health and Mental Hygiene	2	U	distant.	

	•	State Registrar		C	ertificat	te of Dea	ath	R	leg. No.				
Physicia	n	1. Decedent's Name (First, Middle, La Fred Albert Arno	*		,,,,,,			2. Date of Dea Month 5/2	th	Year	3. Time of Death		
/Medic								5/2		-( D - 1)	3:30p		
Examine	er	4a. Facility Name (If not institution, given Crofton Convalesce				, Town, or Loca cofton	ition of Death	4c. County of Death Anne Arundel					
Funeral		5. Social Security Number 6. S		e (In yrs. last birthda	y) If Unde	r 1 Year   If U	nder 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Forei		
Director		214-36-3356 Usual Residence of Decedent	<b>13</b> M 2□F	76 Yrs.	Months	Days Ho	ours Min.	4/9719	3 <sup>Year)</sup>	Mar	yland		
ž * =		10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Limi		
f ehc	ខ្ម	MD Prince Ge	eorge	Upper Mai	r1boro	)					1 ☐ Yes 2 <b>₹</b> ☐ N		
280	Funeral Director	10e. Street and Number	LOTEC	opper man		p Code		1	10g. Citizen of W	Vhat Cou	ntry?		
300	<u>_</u>	18811 Central Ave	⊇.		2	20774			U	SA			
S S E	ner	11. Marital Status	12. Was Decedent Armed Forces?		3. Was Dece	edent of Hispan	ic Origin? (Spec	cify Yes or No-		e - Americk, White,	can Indian,		
within 72 hous aries death with the waryland than "naturel", or items 23e or 28e-f ehow ite Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 H		1 ☐ Yes		ecify:	rican, etc./	Specify	* **	nite		
nature Jical E	Completed	15. Decedent's E	ducation	(Gi	ve kind of wo	ual Occupation	most of working	ng	16b. Kind of Bu	ısıness/in	dustry		
9 5	np.	Elementary/Secondary (0-12)	College (1-4or	life	. DO NOT L	use retired)	,			_			
ygier her ti		7			Clerk		Marka da Mara	/5: A1:	Retai				
az should be nieu within h and Mental Hygiene. 7 ie marked other than " iraumatic event, tra Mes.	Be	17. Father's Name (First, Middle, Last, Robert Daniel Art					Mothers Name Elsie Oa	• •	Maiden Sumam	10)			
d Me nark	유	19a. Informant's Name/Relationship (		10b Ma	iling Address	1			r, City or Town,	State 7i	- Code		
alth an alth a		Fred A. Arnold I	• • • • • • • • • • • • • • • • • • • •						te, PA				
pentin: rages I and a should be they within 72 hours after death with the maryfall Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or Items 23e or 28e-1 ehow any injury or other traumatic event, tra Medical Examiner must be notified at once.		20a. Method of Disposition 1 ∰ write 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Dis cemetery, co Lakemont	rematory or	other place)	1	ate 007 D	20c. Location - avidson				
Departr Departr Importa any inju	Ì	21. Signature of Funeral Service Licer	asse Arall	//				-	uneral MD 214		, P.A.		
hysician /Medical Examiner	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):  a consequence of):	ulifve	- Pul4	nenery	<u>ung</u>					
ing physician and as the burial-transit	Medical E		_d										
	Completed by Physician/Me			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s <sub>j</sub>				23d. Dat Mo	e of deliventh	ery Day Year
een signed by the		Part II. Other significant conditions of	contributing to death b	out not resulting in the	underlying	cause given in	Part I.			ribute to t 3 □ Prol	he cause of death? pably 4 Munknov		
9 2 9 2 9 2 9 3 9 5 9 5 9 5 9 5 9 5 9 5 9 5 9 5 9 5	omplet							24a. Was a autop perfor	med?	death?	opsy findings availat impletion of cause of		
certificete	0	25. Was case referred to medical				26.	Place of Death	1 ☐ Yes		163	271110		
9 9	ToB	examiner? 1 ☐ Yes2 SNo	Hospital:	ent 2 ER/Outpat	ient 3∏ D	100			lence 6 □Oth	er (Specii	٠ ( <del>١</del>		
i si		27. Manner of Death	28a. Date of Inju (Month, Da			28c. Injury at Work?			ow injury occurr				
S id	Ë			,,,	М	1 🗆 Yes				er or Rur	al Route Number,		
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isal of Attending Filys is after death. ral Director; After this led in by the funeral di	Medical Certification:	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only (Check only 2) Medical Example (C	28e. Place of Injuding, et	of my knowledge, de	eath occurred investigation	d at the time, dan, in my opinion	n, death occurre	and due to the ded at the time, d	cause(s) and ma	and due t	o the cause(s)		
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2007 16605

			- For State		Certific	cate of i	Death_					eg. No.		- 1	3. Time of Death
p.	Physicia	n/	egistrar I. Decedent's Name (First, Midd							2	Date of Dea Month May 14, 2	Day 2007	Year		1722 hrs
	Exami		Jennifer  4a. Facility Name (if not instituti	Lee	er)	Aus	stin o. City, Tow	n, or Lo	cation of	Death		40	. County of	Death	
			ta. Facility Name (if not instituti Peninsula Regional	ion, give street and numb	51)		Salisbur					١	Vicomio	0	
				To Con 17	Age (In yrs. last b	irthday)	If Under 1	Year	If Under	24Hrs.	8. Date of B	irth (MM	(DD/YYYY)	9. Birth	place (State or
	Funeral		5. Social Security Number			it it iddy)	Months	Days	Hours	Min.				Foreigr	ntryMaryland
	Director	1	220-13-7958	1 M 2 X F	29	Yrs.					2-22-	19/0			That y Land
			Usual Residence of Decedent		To all T				_						10d. Inside City Limits
	any		10a. State 10b. County	y	10c. City, Tow	n or Localic	Ж							- 1	1 X Yes 2 No
	bow G.	-	MD Wice	omico	Sali	sbury						10 0	tizen of Wh	ot Cour	tn/2
	Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Co	ode				10g. G	lizen or vvi	iat Gouin	uy:
name of the	or 28	Ë	401 S. Park Di	civo				2180	)1				USA		
	ith th		11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Was	Decedent	of Hispa	nic Origi	n? (Spe	ecify Yes or N	lo-	14. Race White		can Indian, Black,
	th w	Funeral	1 Never Married 2 X	Married Armed Ford	es?	If Ye	es, specify (	Cuban, i	Mexican,	Puerto i	Rican, etc.)		111111	, 0.0.	
	r dez	교		1 Yes	2 X No	1	Yes 2 X	No	specify:				Specify:	Whit	:e
	s afte	à	15. Decedent's Education (S	or Dates:	completed) 16	a. Deceden	t's Usual O	ccupatio	n (Give k	ind of w	ork done	16b.	Kind of Bu	isiness/l	ndustry
	hour natu Exan	ba	Elementary/Secondary (0-1			during me	ost of worki	ng life. (	DO NOT (	ise retir	ed)				
ď	n 72 nan "	Set		2)	,	(	Cashie	r					Gas S	tati	ion
5	withi iene.	Complete	12 17. Father's Name (First, Midd	(lo l act)			Jabilie	1	3. Mother's	s Name	(First, Middle	, Maide	n Surname	e)	
4	Hyg doth	Ü						-   -	Dehoi	rah	Donoho	e.			
2424E 003E	ILLISTOCO Id be filed within 72 hours after Aental Hygiene. narked other than "natural" event, the Medical Examine.	Be	Doyle Kellet	L Print (Type Print )		19b. Mailing	Address	(Street	and Num	ber or R	tural Route N	umber,	City or Tov	vn, State	e, Zip Code)
- 6	L I I I 3-0000 should be filed within 72 hours after death with the Maryland and Mental Hygene. This marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once ratic	_T			- 1.						isbury	7. M	arvla	nd 2	21804
2	MD 2 should be a should be a should be and a should be	'	Jason W. Aust:	in - husband	20b. Pla	ce of Dispos	ition (Name	e of cem	etery.	Dur	Date	200	c. Location	- City or	Town, State
ç	s l ar f Hea If ite		1 Burial 2 X Crema	tion 3 Removal from	crei	matory or ot	her place)		1	- 1	0 0007	,   ,	. 1	D	1 0 0 0 0 0
	Page ent o		4 Donation 5 Other		Crema	atory	of De	lma	rva	5-1	9-2007	ען	elmar	, D€	elaware
3	Baltimore, MD Z1Z13-03-03-09-09-0-03-0-03-0-03-0-03-0-03-		21. Signature of Funeral Serv		1		Name and A				lounds				
Ġ	E E E E		Molesso 7	Levy Slo	ire	705	5 E. N	<u>lain</u>	Str	eet,	Salis	sbur	y, Ma	eart	and 21804 Approximate Interval
7	ysician		23z. Part I. Enter the disease failure. List only one cal	, or complications that car	used the death. D	o not enter t	the mode of	ayıng,	such as c	ardiac d	respiratory	arrest, t	SHOOK OF H		Between Onset and Death
	Ac firs	0.1	Immediate Cause (Final dise	The second secon	1 intoxica	tion									Dodan
	Examine		or condition resulting in death	h) Due to (or as a	consequence of):										
			Sequentially list conditions,	b					_	_		-			-
		ĕ	if any, leading to immediate		consequence of):										
		Ē	(Disease or injury that initiate	ed <del></del>	consequence of):										
	ed sit	Examiner	events resulting in death) La	d.	,										
	Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and according to a part of the death of the new set the limital - transit	<u>e</u>	X UNPENDED					100 10							
	), be ex siciar siciar	Medical	1 UNPENDED	#23a,27	,28a-f, pe	rME. ga	367. 5/	29/0	7 <u>-1-1-</u>	_		$\neg$	23d. Date	of delive	ery
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	68 certif nding	sician	past 12 months?		ant at time of deat		Other (Spec								
	Box 68 te death certif the attending	Sic													t dooth?
	that the death certifi- ned by the attending	P	Part II. Other significant co	onditions contributing to	death but not res	sulting in the	underlying	cause	given in F	Part I.					to the cause of death?
	P.C	<u>غ</u>									1 _	Yes			robably 4 V Unknown
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	ord wrea										r	erforme		death'	?
	ec.	Completed							_			es 2	No	1 🗸	Tes 2 110
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	/ita	8		Hospital:	Inpatient 2	ER/Outpatie		OOA			ing Home 5		esidence (	h	ner.
	B Ph.	E 2			of Injury n, Day,Year)	28b. Time o	of Injury		iry at Wo			inde no	w injury occ	uneu	
	In the light of the last of th	<u>ַ</u>	1 Natural 5	Pending Fnd	5/14/2007	FNd 2	:30 pm	1	Yes 2	X No	unk	-			
	Sic Atte	60 2	2 Accident	Investigation 28e. Plac	ce of Injury - At ho	me, farm, st	reet, factor	y, office	building,	etc.	28f. Locat	ion (Str wn. Sta	eet and Nu te)	mber or	Rural Route Number, City
	Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death.  eral Director: After this certificate has been signed by each of the deach.	nilled in by the tune	3 Suicide 6 X	Could not be determined (Specify)	other-s	scene					401 S	. Pa	rk Ave	nue S	Salisbury, MD
	ie so	~		ing Physician: To the be			curred at th	e time,	date and	place, a	nd due to the	cause(	s) and mar	ner as s	stated.
	he Ho n 24 ne Fu	completely	(Check only one) 2 Medica	I Examiner: On the basis	of examination ar	nd/or investi	gation, in m	y opinio	n, death	occurre	d at the time,	date ar	nd place, ar	nd due to	tne cause(s)
	To the 1 within 2 To the	com	29b. Signature and title of c	and mainer.	stated.				se numb				29d. Date s	signed (	Month, Day, Year)
		2	290. Signature and title of t		1			0.0	M.E.				May 15,	2007	
	_		Calo	uch	/>	7									
			30. Name and address of p		use of death (Item	23a)	enn Stre	ot Po	ltimoro	MD 1	21201				
			Zabiullah Ali, M.D	180	cal Examiner	111 P	em stre	et, ba		, 1410					
		Sta	e 31. Date filed (Month, Day,		Registrar's Signatu	ire	West of								
		4.4	MEANY 2	4 LUUI MANGE	HARA AN	63									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Bullock **Physician** MAGELINE MARIE 1122 M 2007 Mai /Medical 4c. County of Death 4b. City\_Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner ENINSULA REGIONAL MEDICAL ALISBURY CENTER NICOMICO If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 □ M 275€ 218-34-3360 7-22 -MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10b. County 10c. City. Town or Location "natural", or Items 23a or 28a-f show ediçal Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND Wicomico 10g. Citizen of What Country? 10e. Street and Number CANNON 21804 30380 U.SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Markin Injury or other traumatic event injury event injury event injury or other traumatic event injury event eve 1) omestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HATTIE ti Eld M)ASON SIZ ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARRIOTEVILLE Rd YRONE Bullock Owings SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill HEDRON. 5-12-07 GARDENS 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Stewart Fun. Home 821 WESTRd. Glade 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical the as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No ed by the detached Division or Vital Records, P.O. 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No 1□ Yes 2☑No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1, Inpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this recompletely filled in by the funeral was 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Datę signed (Month, Day, Year) 29b. Signature and title of certifier 10 18 nd address of person who completed cause of death (Item 23a) (Type, Print) vakumon mi aman

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

08

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** a May 4, 2007 3:50 Elizabeth Brown /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 9326 South Fork Road Parsonsburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 10/18/1932 Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗙 F Yrs. 74 Director Maryland 214-30-7713 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Itema 23s or 28s-f show other traumatic event. The Mudical Examinar must be notified at 1X Yes 2 □ No Funeral Director Maryland Wicomico Parsonsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 21849 USA 9326 South Fork Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within f Heelth end Mental Hygiene. Item 27 le marked other then College (1-4or 5+) Elementary/Secondary (0-12) 10 Line Worker Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luther Webster Irene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Jim L. Brown/son 35907 E. Line Rd., Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₹ <u>=</u> 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6 permit. Page Depertment of Important: If any Injury or once. Jerusalem U.M. 5/7/07 Parsonsburg, MD Church Cemetery 5//0/ Parsonsburg, MD

2. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Litenses Kerll, Canal 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ischemic **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as I ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral ( 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospitel or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital

deeth with the Maryland

filed within 72 hours after

Pages 1

Baltimore, Maryland 21215-0036

within 24 hours efter death To the Funeral Director: filled in by

DHMH 17 Rev 1/2001

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature.au

title of certifier

DAVIS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

1 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

054127

Salishu

MD

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

lower

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan	•	artmer rtificat			and M	ental Hyg	giene () leg. No.	007	16608	
			1. Decedent's Name (First, Middle, L	.ast)							2. Date of Dea Month	th Day	Year	3. Time of Death	
П	Physici /Medic		Nannie Bucha	anan				May					007	7:33A M	
	Examin		4a. Facility Name (If not institution, g.	ive street and nun	nber)		4b. City	Town, or	Location o	f Death		4c. Co	ounty of Deal	th	
			Southern Mary						nton					Georges	
	Funeral		5. Social Security Number 6.	.Sex 1 ☐ M 2 🔯 F	7. Age (In yrs.	Ven	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	r, Year)	9. Biri	thplace (State or Foreign ountry)	
	Director		579-80-0581		8	5 Yrs.					Jan.4,	1922	2 VA	·	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	
	Aaryl Faho	ō	M-J DC		C.	apitol	цо	iah+	c					1 MYes 2 □ No	
	28a-	Director	Md. PG  10e. Street and Number		Co	preor		Code	5			10g. Citize	n of What Co	ountry?	
	Mith Ba or	٥	342 Carmody H	ille Dr	1 170			2074	3			Uni	ted S	tates	
	Jeath The 23	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.				gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ame	erican Indian,	
(0	riter	표	1 Never Married 2 Married		2 🔯 No					, Puerto F	Rican, etc.)		Black, Whit	e, etc.	
ලි	er's	þ	3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ates:		1 🗌 Yes	2 <b>X</b> 1 No	Specify:			Si	pecify: Bl	ack	
က်	72 hg	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usu	al Occupa	ition furing most	t of workir	ng	16b. Kind	of Business	/Industry	
21215-0036	ithin	ig.	Elementary/Secondary (0-12)	College (1	-4or 5+)	`life.	DO NOT I	ise retired	)			70	t .		
7	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23a or 28a-f ahow the than Madical Examiner must be notified at		12	-41			Hou	sewi		de Name	(First Adjusted)		ivate	:	
ב	be fill	Be	17. Father's Name (First, Middle, Las	St)							(First, Middle,	Maideri St	imame)		
<u> </u>	J Mer Jarke	၉	Unknown	(T. (D.) (1)		401 14 16	A 1.1	(0)		nowr		. 02 7	C1-1-	Zi- Code)	
Maryland	12 st h and 7 ia n traun		19a. Informant's Name/Relationship		•						l Route Numbe	r, City or i	own, State,	Zip Code)	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Important: it item 27 is marked other than "natural;", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Examiner must be notified at Once.		Josephine Kin	g/daugn	cer 20b. F	Temp	sition (Na	Hill me of	bri s, M	Q . 2	20748 ate	20c. Loca	tion - City or	Town, State	
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Baltimore,	it. Partme		4 □Donation 5 □ Other (Special Signation of Funeral Service Lice	-	Ced	dar Hi					dges &				
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			23a. Party. Enter the disease, or co shock, or heart failure. List on	implications that c	aused the deal									Approximate	
	Physician		Immediate Cause (Final											Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)		or as a consec		DIT	_ []	NFAR	CII	010				
	Examiner			Cox	CONAR	4 AR	JER	4	DISE	AJE					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consec										
d'h	ocuter and trans	Examiner	Cause (Disease or injury that initiated events	c				_							
8760,	e exe	ũ	resulting in death) Last	Due to (	or as a consec	tneuce ot):									
876	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical		d						-					
9 X	ding	/Me	IF FEMALE:	23c. If yes, out	come of prean	ancv					-	22	d. Date of de	livery	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live b	irth 2 Feta	aldeath 3	⊒Ectopic p ⊒ Other (s					20	Month	Day Year	
<u>Р</u> О		ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unkno				,,,,,							
	law requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions	s contributing to de	eath but not res	sulting in the u	ınderlying	cause give	en in Part I.		23e. Did to	obacco use	contribute t	o the cause of death?	
rds	w requires t been signe should be	D D	DIABETES								101	′es 2 🖭	No 3□P	robably 4 Unknown	
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<u>ta</u>	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	(Check only o				
<b>\$</b>	Physician: r this certific ral director.	To B	examiner? 1 17 Yes 2 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4 □ Nu	ırsing Hor	ne 5 ☐ Resid	ience 6 (	□Other (Spe	ecify)	
0	ng Pt		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	of	28c. Injun Worl	at c?	2	28d. Describe h	now injury	occurred		
<u>Ö</u>	Attanding r death. ector: Atter by the fune	atle	2 ☐ Accident investigat				М	10	Yes 2 🔲						
Division of Vital Records,	of Attand after death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ed 289. Place	of Injury - At h ng, etc. (Speci		reet, facto	ry, office		4	28f. Location (5 City or Tox		Number or R	lural Route Number,	
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	To the l within 2 To the l complet	Σ	29b. Signature and title of certifier					c. Licens		. 1				th, Day, Year)	
)			- Joseic					04	032	4		MIT	14,2	)00 t	
	2		30. Name and oddress of person what TERLY JODRIE		se of death (Ite		Print)	20 AP	. CL	INT	on m	ARYI	Ans	20735	
	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Şign			- 1544	•						
	Regist		MAY 2 2 200	7 Bluen	15	1084	28								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 2, Cochran 2007 Annette Lynne 5:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🖫 F Months Days Director 220-94-3804 18, 1965 Washington, the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō must be "natural", or Items 23a 8210 Colonial Lane 20910 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 is marked oth any injury or other traumatic event David C. Cochran Beverly J. Eckberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 9th Street South, Arlington, VA 22204 Beverly Devlin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 8, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5 Other (Specify) 4 □ Donation Metropolitan Crematory 2007 Alexandria, Virginia 21. Signature of Funaral Service License 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications to taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed acistrointestira and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No ed by the 9 Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 2 No the Hospital or Attending Physiclan: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DUBUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Day, Year)

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31. Date filed (Month

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egistrar's Signature

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2007

Sunsatts Rel, Clinton no 20731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1105 M **EDWARD** CLIPPER Ν. 2007 MAY l, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14044 Berryville Road Germantown MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex M 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 50 219-68-5712 Yrs. Feb.10,1957 Director Wash. DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State пs 23a or 28a-f show must be notified at 1 X Yes 2 ☐ No MD Director Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with items 23a 14044 Berryville Road 20874 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: Black þ 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 vrs other than Elementary/Secondary (0-12) the Religion Minister yrs permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 is marked other th
any Injury or other traumatic event, tha
ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton C. Clipper, Sr Gladys R. Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coden 8 7 4 19a. Informant's Name/Relationship (Type. Print) Gladys R. Clipper (Mother) 14044 Berryville Rd, Germantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Femation 3 ☐ Removal from State Riverdale Pk Crem 5/4/07 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Sig atur of Theral Service Licen 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallere. List only one cause on ead; line. Immediate Cause (Final disease or condition resulting in death) **Physician** myoc /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□ No 24a. Was an autopsy performed? Yes 21 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: ဥ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;

completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defining Physician: 10 file best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sonature and title of certifier 12 00 45 2007 UNMOME 8) 1 2101 melical 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar mo omE

edistrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 12:45 P M May 4 2007 /Medical Disdier Pierre 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex Chevy if Under 1 Year Montgomery

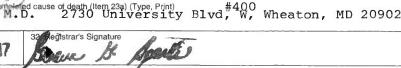
9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1₩ M 2□F Months Hours Director 519-07-1565 Usual Residence of Decedent 88 Nov. 7, 1918 Idaho 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Florida Collier Naples 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 260 Countryside 34104 USA Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? ₩₹Yes 2 □ No if Yes, Give Year or Dates: 1942- Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify.White þ 3 Widowed 4 Divorced 1942-45 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Economist State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental F fitem 27 Is marked otl Pierre Jean Disdier Josephine Bertha Taillet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret D. Disdier/ Wife 260 Countryside Drive, Naples, FL 34104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 7. 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑ Other (Specify)Entombment Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Sign dure of uneral Service Licensee Francis J. Collins Funeral Home Inc. Mehard I Holes 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Cancer 1 Month /Medical Due to (or as a consequence of) Examiner Bladder Cancer 8 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical use as i IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 Tes 2 No 3 Probably 4 Unknown Ischemic Cardiomyopathy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy pertormed? 2□ No 1 Yes 2 XNo 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}$  X Other (Specify Daughter's P 2 X No 2 ER/Outpatient 3 □ DOA After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Residence Certification: 1 Natural injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

30. Name and address of person who Linda M. Burrell,

MAY 0 7 2007



State

Registrar

D35996

4, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1202M + even Dunham 05 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anchorag Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 06. Sex 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yo 6-7-1943 **Funeral** Months Days TO M 20 F Hours Min 3 100 6 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 28a-f ehow other treumatic event, the Medical Examiner must be notified at TX Yes 2 No Director Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1400 N. Arbutus Drive 21804 USA or iteme 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if Item 27 ie marked other then "netural", or item eny injury or other treumatic event, the Medical Examina": 9069. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bricklayer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fayatte Richard Dunham Evelvn Weese 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Bannon - sister 1400 N. Arbutus Drive, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Springhill Memory Gds. 5-10-07 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Maryland 22. Name and Address of Facility 21. Signature of June al Service Licensee Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ameroscheurti Candirvascular dina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use es the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) the deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be Ullcer. DE CURITUS. 1 Yes 2 No 3 Probably 4 Onknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an certificete has page 2 autopsy performed? 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: Algorithms of the funeral points investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Malin ans D32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milrord St SOUB Salis Brug MIS 21809. MOONDIA MAHOSH 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** James 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisburg Lake Wicomico ioa stal Hospice at the Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours M 2 F 72 Director /21/1935 220-30-1755 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 108 Center St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EBA Engineering, Inc. 12 State Highway Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ivan Grove Egbert Catherine Wareheim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 108 Center St., Salisbury, MD 21801 Deborah Jean Egbert/wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/7/07 Hebron, MD Gardens Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 ral Service Licensee Wompoon CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metatatic (olorectal **hysician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death cortificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the Division or Vital Records, P.O. 9☐Unknown 9 ☐ Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No. 3 Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an , page 2 autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes SE No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death Director: A in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in by hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bux 1233 (ono/ 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month **Physician** 2007 Dozya **GOROKHOV** 4 5:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth North, Day 5, 1923 Soviet Union 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-21-2492 1 ☐ M 2 🖺 F 83 Director Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural?" or flower other trainmants. 10c. City, Town or Location Gaithersburg 10d. Inside City Limits Montgomery 1 ∑Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2087.7 U.S.A. 17100 Downing St., #301 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 27 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Ž No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Usher Koyfman Yekaterina Berkovitch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Gorokhov / son 1284 Bartonshire Way, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gard. May 6, 2007 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Furleral Service License 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed signed by the attending physician and abe detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 perform 1 Yes 2 No 1 Yes 2 No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this: ို 2X ER/Outpatient 3 □ DOA 27. Manner Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Laturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAY 0 7 2007

David Klein, MD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year) May 5, 2007

			For State Registrar	State of Mary		rtificate of L			giene Reg. No. 🤈	007	16515
ir i	Physicis	3	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		JOHN JAMES GERWI			4b City Town or	Location of Death	MAY	1 4c Cour	2007 nty of Death	7:14 <sup>1M</sup>
L	Examin	er	4a. Facility Name (If not institution, g  ANNE ARUNDEL MED			ANNAPOLIS				ARUND	FT.
	Funeral			Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h		lace (State or Foreign
	Director		217-52-3791	1 <b>X</b> M 2□ F	58 Yrs.	Monard Days		MARCH 1			
	land t	}	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sho fied a	tor	MARYLAND QUEEN A	NNE'S CI	HESTER						1 ☐ Yes 2 X No
	or 28a e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	try?
	ath wi		114 MERGANSER COL			21619			UNITED	STATE	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It has 23 or 23 or 28 or	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, Mexican, Puert	o Rican, etc.)	В	Black, White,	etc.
ה ה	72 ho natur dical I	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king		Business/In	•
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ole	0 ° ± 5		20a. Method of Disposition 1 ☐ Buria! 2 🛣 Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cre	nsition (Name of matory or other plac		Y 3,	20c. Locatio	on - City or To	own, State
	it. Pag rtment rtant: njury		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lic			E CREMAT					, MARYLAND D NEWNAM
Dall	permit, Pag Department Important: any Injury o		I Will Eller		)672   C	REMATION  14 BESTGA	AND FUNE TE ROAD	RAL CARI	TS. MA		
,O,	Physician and Medical Examiner is the burial-transit	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause of conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a co	onsequence of):  have juence of):  abe fee	0	ng, such as cardiac		rrest,		Approximate Interval Between Onset and Death
P.O. BOX 68/6U	w requires that the death certificate been signed by the attending physic should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	Fetal death 3[ le of death 5[	□Ectopic pregnanc: □ Other (specify)		22a Did+		Date of delive	ery Day Year
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Hecord	e lav has je 2	Completed						24a. Was auto perfo	an 24 psy prmed? 2 No	4b. Were auto prior to co death? 1 ∐Yes	opsy findings available mpletion of cause of
۷па	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o			
_	Physician: r this certific ral director,	To	Yes 2□ No		2 ER/Outpatie		4 Li Nursing F	lome 5 ☐ Resi			fy)
DIVISION O	ending eath. or: After	Certification:	27. Manner of Death    Natural   5   Pending   2   Accident   investigal   3   Suicide   6   Could no	t be 280 Place of injuny		M 1	ry at rk? ]Yes 2 □ No	28d. Describe			al Route Number,
2	声를	ertif	4 ☐ Homicide determine	building, etc. (		,,		City or To			,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Ex	Physician: To the best of n caminer: On the basis of ex and manner stated	amination and/or in	nvestigation, in my	opinion, death occ		, date and pla	ce, and due t	o the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year **Physician** may 2210 8 M tothia 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore )ohns HOOKINS HOSpital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2MF Director March 22,1971 212-94-5266 36 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show r 28a-f show notified at MD Charles Charlotte Hall 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 11651 Stines Store Road 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other tremmans. Office Manager <u>Auto Body</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Charles Cinnamond Eleanor Cinnamond-Guy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Cinnamond-Guy/Mother 11651 Stines Store Road, Charlotte Hall, MD 20622 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Newport Cem. 5/10/07 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 4 /auz 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): days /Medical Examiner ung transplants Sue to (or us a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 3 Probably 1 ☐ Yes Completed page 2 should peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No certificate has autopsy performed? Yes 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No 1 ☐ Yes 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death. After 1 Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who complete

RVCT

Ellison

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Ne of death (Item 23a) (Type, Print)

32. Raistrar's Signature

Michael Holmone	e, Jr	1 10	Sta	ate of Maryla					Menta	i Hyg	iene	0.0	, , , , , , , , , , , , , , , , , , , ,	
_		- For State Registrar			Ce	ertificate	of Deat	h				3. No.	14/	1661
Physicia		Decedent's Name									Date of Death Month	Day Year		Time of Death 2145 hrs
Medical Examin		Michae 3		mone Jr			4b. City. T	own, or Lo	ocation of E		May 11, 20	4c. County of D		
3		Prince Geor		-	anibor,		Chev					Prince Geo	rge's	
Funeral	7	5. Social Security N		6. Sex	7. Age (In yrs.	. last birthday	) If Unde	er 1 Year	if Under 2	24Hrs. 8	8. Date of Birth	(MM/DD/YYYY) g	. Birthpla	ace (State or
Director	- 1	577-06-	27/1	1 XM 2 F		25	Yrs. Month	s Days	Hours	Min.	Aug 6	, 1981	oreign Countr	hDC
	ŀ	Usual Residence of												
v any		10a. State	10b. County			ty, Town or Le								d. Inside City Limits  X Yes 2 No
and F show	5	DC			Wa	ashin					140	g. Citizen of What		
Maryl 28a-	Director	10e. Street and Nu					10f. Zip		_		10		•	
th the			cant S	Street,				2001		2/5000	ify Yes or No-	United States  14. Race - American Indian, Black,		
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er des		3 Widowed	townson.	1 Yes orced If Yes, Give Ye	2 X No	1	Yes 2	X No	specify:			Specify:	3lac	ck
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5-0036 lled within 7 Hygiene. I other than	ם	12					Firef					Engine	Co.	. 19
5-0 iled w Hygin flothe		17. Father's Name										laiden Surname)		
2121 suld be fi Mental I marked ic event,	Be	Michael  19a. Informant's Na		none Sr.		19b. M	ailing Address	s (Street	and Number	er or Rur	e Gre	mber, City or Town, State, Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	유			een/moth	er	122	Atla	ntic	St.	, 28	E2#2	•		1
and 2 and 2 lealth item 2		Verneice Green/mother    22 Atlantic St., SE #2									ty or To	wn, State		
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O. Box 68760 that the death certificate the death certificate the by the attending physical detached for use as the bu	, Ph	Part II. Other sign	ificant condi	tions contributing	to death but no	ot resulting in	the underlyin	ig cause g	iven in Parl	t I.		bacco use contribu	_	
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DIVISION OF VIEW Parks of Examiners (Check only one)  The female of the							, 011001/100101	,,			or Town, S			
The second secon						ledge, death	occurred at th	ne time, da	ate and plac	ce, and c	due to the cau	se(s) and manner a	s stated	
29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated.						on and/or inve	estigation, in r	ny opinion	, death occ	curred at	the time, date	and place, and du	e to the	cause(s)
Mi To	Me	29b. Signature an	d title of certif	ier			2	9c. Licens				29d. Date signed		n, Day, Year)
		hi	n	i, m	1			O.C.	M.E.			May 12, 200	17	
-				n who completed ca		Item 23a)	Dina -4 D	Alma - :	MD 040	01				
15		Ling Li, MI		ant Medical Ex	20		Street, Bal		IVID 2120	U I				
S	tate	31. Date filed (Mo	nth, Day, Year	2 2007	Registrar's Sigi	nature,	freely							

DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Month, Day,

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32. Registrar's Signature

OSLER DRIVE TOWSON, MARYLAND 21204

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene Reg. No.2	007	16620
. Say	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	al -	MICHAEL ANTHONY JACKSON  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De-	May		2007 unty of Death	8:45 A M
	Examin	er	FREDERICK MEMORIAL HOSPITAL FREDERICK			FREDERI	CK
	Funeral Director		5. Social Security Number 2 1 2 - 7 8 - 4 8 9 8  6. Sex 1		ay, Year)	9. Birthp Coun M I	
	/land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	a-f sh	ctor	MD Frederick Frederick				1⊠Yes 2□No
	vith the	Director	10e. Street and Number 10f. Zip Code			of What Coun	try?
	leath v	Funeral	1100 Wilson 21701  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No		S A Race - America	an Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	if Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	erto Rican, etc.)		Black, White, one of the Black, White, one of the Black, White, one of the Black, White, or the Black, White, whit	
21215-0036	72 ho "natur	Be Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	orking	16b. Kind	of Business/Inc	lustry
72	within iene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)  Not Employed			None	
pu	al Hyg l other	3e C	17. Father's Name (First, Middle, Last)  18. Mother's N.	ame (First, Middle	, Maiden Sui	rname)	
Maryland	ould b Ment harked	To I	Walter Jackson Ruth	Jackson			
Ma	nd 2 sh Ith and 27 is n traum		19a. Informant's Name/Relationship (Type. Print)  Wendy Ransom Medical Coor 2090 Old Farm Dr.		-		
ř,	s 1 ar of Hea item 2		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		ion - City or To	
altimore,	Page ment c ant: If ury or		4 Donation 5 Other (Specify) Smithsburg Crem. 5/	15/2007	Smit	hsbur	g, MD
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	00 = % O		23a. Pagy. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card			ick, M	ID 21701 Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or conditions resulting in death)  Sequentially list conditions, if any, leading to immediate  List only one cause on each line.  Jue to (or as a consequence of):  Due to (or s a consequence of):	vith Se	sir	)	Interval Between Onset and Death
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Divis	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and N wn, State)	umber or Rura	Route Number,
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)	Mith To t	Σ	29b. Signature and title of certifier  29c. License number  D-/397/	/	29d. Date	gned (Nonth, I	Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
8	Sta	te	Robert L. Kauf Mann M.D. 300 West Ninth St. F  31. Date filed (Month, Day, Year)  AAY 2 2 2007	rederic	K, MD	21/0	1
	Registr	ar	MAY & & COUL				

	1	State	Department of Health and N  Certificate of Death		- 211117	16622
Later and		Registrar  1. Decedent's Name (First, Middle, Last)	Detinicate of Death	Reg. 2. Date of Death		3. Time of Death
Physicia	n	Linda Norene Lightbody		Month Mav	02, Year 2007	2:50 p <sup>M</sup>
/Medica Examine	De la	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	± 74	Greater Laurel Health & Rehab	Laurel		Prince Ge	eorges
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last i	birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		ace (State or Foreign y)
Director	-	213-50-6013 60 Usual Residence of Decedent		May 09,	1946   Mary	land
yland now at	İ		own or Location		10	d. Inside City Limits
a-f sh	cto	Maryland Prince Georges Lau	rel			1 ☐ Yes 2 No
or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Countr	
s 23a	era	14200 Laurel Park Drive 11 Marital Status 12. Was Decedent Ever in U.S.	20707	ecity Ves or No-	United Sta	
iter de item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☐ Married  1. ☑ Never Married 2 ☐ Married	13. Was Decedent of Hispanic Origin? (Sp If Yes, specity Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
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72 hol natur lical E	Completed	15. Decedent's Education (Specify only highest grade completed)	<ol> <li>Decedent's Usual Occupation         (Give kind of work done during most of work life. DO NOT use retired)     </li> </ol>	ing 16	b. Kind of Business/Indu	ustry
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iled w Hygier her th	ပ္ပံ	17. Father's Name (First, Middle, Last)	Letter Carrier	e (First, Middle, Ma	IS Postal Se niden Surname)	ervice
d be fi	ă	Albert Lightbody		Collins	,	
should mark mark	ို		9b. Mailing Address (Street and Number or Rui		City or Town, State, Zip (	Code)
alth a 27 is 27 is		John White / Son 3	340 Lancer Court, Dun	kirk, Mar	yland 20754	<u> </u>
of He rothe	1	20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State	of Disposition (Name of etery, crematory or other place)	Date 20	Oc. Location - City or Tov	vn, State
Pag ment ant: ii ury o		4 □ Donation 5 □ Other (Specify) Ft.	Lincoln Crematory 5/0		Brentwood,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire 77 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Pervice Licensee	22. Name and Address of Facility Simple Tribute Fune 1040 Rockville Pike	. Rockvil	le. Marvlar	enter nd 20852
		23a. Part1 Chiter the disease, or complications that caused the death. Established for heart failure. List only one cause on each line.	Oo not enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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/Medical Examiner		resulting in death)  Due to (or as a consequence)	ce of):			
CONTRACTOR	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence)	ce ofi:			
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cate be executed physician and the burial-transit	dical	d				
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Physician: The law requires that the death certificate has been signed by the attending trail director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 12 months? 4 ☐ Pregnant at time of deat	ath 3 ☐ Ectopic pregnancy		23d. Date of deliver Month	ry Day Year
the de	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	Oli Other (speciny)			
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ding F	ion	1 ☑ Natural 5 ☐ Pending (Month, Day Year)	b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. Describe now	injury occurred	
Atten death cctor: y the	ficat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home		28f. Location (Stre	eet and Number or Rural	Route Number,
after after din b	Certification:	4 ☐ Homicide determined building, etc." (Specify)		City or Town,	State)	
To the Hospital or Attending within 24 hours after death of the Funeral Director. After completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place a and/or investigation, in my opinion, death occu	, and due to the cau irred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
o the comple	Mec	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, I	Day, Year)
2		16/mm/ Hell	0053235	М	ay 04, 2007	
2		30. Name and address of person with completed cause of death (Item 23	Ba) (Type, Print)			
		Darryl A. Hill, M.D. 13635 Bal	timore Avenue, Laurel	, Marylan	d 20707	
Sta Registr		31. Date filed (Month, Day, Year)  NAY 0 7 2007	Aparti			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Loring 1530 Alice Helen 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 3-26-1934 Illinois Director 354-26-1075 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1X Yes 2 □ No Director MD Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 209 N. Park Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify: Specify:White þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Fischer Susan Harbushka ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 N. Park Drive, Salisbury, Maryland 21804 Donald R. Loring - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Creamtory of Delmarva 5-7-07 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extrahepotic Cholongiocarcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA ို To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

MAY 0 8 2007

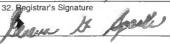
E.

James

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN,



N.O.

030690

185 E. Grall St. Solishury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Felipa Mendoza 2007 May 1, 12:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing and Rehab Kensington Montgomery

9. Birthplace (State or Foreign Country) Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1□M 2**X**)F Months Days Hours Min. Director 98 None May 4, 1908 Honduras Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified 1 TYYes 2 □ No Director Maryland Prince Georges Chillum 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 2, any follary or other traumatic event, the Medical Exercises on 2, any long or other traumatic event, the Medical Exercises or 2. by Funeral 6015 Riggs Rd 20783 Honduras 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Honduras White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homeowner Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Exsequil Rodriguez Vincenta Mendoza 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Moncada/Daughter 6015 Riggs Rd, Chillum, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem May 5, 2007 Adelphi, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Olla 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** FAILURE TO THRIVE /Medical Due to (or as a consequence of): **Examiner** VASCULAR LSCHEMIA CENEBRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perform 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation illed in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Sen, My 513107 20057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troung Bao, MD
31. Date filed (Month, Day, Year) 9715 MEdical Center Dr, #201, Rockville, MD 20850

DHMH 17 Rev 1/2001

State

Registrar

MAY 07 2007

			For State		State of Ma	aryland		ertificate of			, ,	0/		10000
			Registrar  1. Decedent's Name	(First Middle Last)				inioate of	Dea		2. Date of Dea	leg. No.		3. Time of Death
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	/Medic			orge Edward				41. Oh. T	1	i 5 D 4h	May 1	-	u of Dooth	2130
)	Examin	er	4a. Facility Name (If	not institution, give s	treet and number)			4b. City, Town,	or Locat	on of Death		4c. Count	y of Death	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐Cremation 3 ☐R	emoval from State	Park]	lawn 1	ematorý or other p <b>lemorial Pa</b>	rk &	E /7 /	2007	D1	. M	-1 d
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n c	ding Physician: n. After this certific funeral director,		27. Manner of Death	n 5	28a. Date of Inju (Month, Da		8b. Time Injury	/ W			28d. Describe h	ow injury occu	irred	
sio	eath.	ati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be					☐ Yes	2 □ No				
Division	or At ter d lirect	Certification:	4 ☐ Homicide	determined	28e. Place of inj building, et	ury - At hom c. <i>(Specify)</i>	e, farm, s	street, factory, offic	е		28f. Location (S City or Tow	Street and Nun vn, State)	nber or Rura	al Route Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the funer	Medical	29a. Certifier (Check only one)	1 ☑ Certifying Phys 2 ☐ Medical Exami	ner: On the basis of	f examination	eage, ae n and/or	am occurred at the investigation, in m	y opinion	ile and place, i, death occui	red at the time,	cause(s) and r date and place	nanner as s e, and due t	tated. o the cause(s)
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	ס		Usual Residence of Decedent					02/14/	1743	11CW	ociacy	
	anylar how	پ	10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City	
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Ö	raf', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1 □ Yes 2 <b>X</b> N	Specify:		Sı	whit	е	
2-0	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f ehow than "natural", or items 25s or 28s-f ehow fra Madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education trade completed)	16a.	Decedent's Usual Occi 'Give kind of work don- life. DO NOT use retir	upation a during most of	f working	16b. Kind	of Business/In	dustry	
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au	d be sental	To Be	John A. Madden	,				E. Tietz	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Maryland 21215-0036	od Mondard	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Stree	1		er, City or T	own, State, Zip	Code)	
Š	atth a		Carol L. Madden	/ Wife	1.	1821 Bishop	s Conte	ent Mitche	11vi1	le, MD	20721	
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 ehow entry or other treumatic event, the Medical Examinat must be notified at an once.		20a. Method of Disposition 1 Deurial 2 Cremation 3	OD	20b. Place of cemeters	Disposition (Name of , crematory or other pl	ace)	Date	20c. Loca	tion - City or To	own, State	
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н			shock, or heart failure list of	one cause on each	sed the death. Do not ine.	ot enter the mode of dy	ring, such as car	rdiac or respiratory a	rrest,		Approximate Interval Betwee Onset and De	een
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876	Attending Physician: The law requires that the death certificate be executed redath.  r death.  ector: Alth.  ector: Age the this certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	licat	•	d								
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Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су		230	<ol> <li>Date of deliver</li> <li>Month</li> </ol>		ear
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<b>d</b>	Physi this c	2	1 X Yes 2 No	Hospital: 1 Inpa		ALIGIT 3 DOA		ng Home 5 Res			v)	
Division of Vital	ding I h. After funer	tion	27. Manner of Death  1   Natural  5   Pending  2   Accident investigate	28a. Date of II	njury 28b. Ti Da <i>y</i> Ye <i>ar)</i> In	ury W	uryat ork? ∐Yes 2∐No	28d. Describe	how injury o	ccurred		
18	after death after death Director: I in by the	fica	3 ☐ Suicide 6 ☐ Could not	be Oge Diese of	Injury - At home, fan	n, street, factory, office		28f. Location (	Street and N	lumber or Rura	I Route Numbe	8/
á		Certification:	4 Homicide		etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To				
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier 1 Certifying F	Physician: To the be	st of my knowledge,	death occurred at the	time, date and p	place, and due to the	cause(s) an	d manner as s	ated	
	the H in 24 the Fi	Medical	one/	and manner	stated.	or investigation, in my		occurred at the time,	date and pla	ace, and due to	the cause(s)	
	To with	2	29b. Signature and title of certifier	10-	-		ise number	7		igned (Month,	Day, Year)	
•			Larson	14/3	440	15	005592	-/	MAY	3, Z00	7	
	150		30. Name and address of person wh	o completed cause of	of death (Item 23a)	ype, Print)	e Cho.	verly M	1140.	Laters D		
904	Sta	te.	31. Date filed (Month, Day, Year)		strar's Signature	100	/	7	7/	2122 0		-
	Registr		MAY 0 7 200	7 Steam	JK A	Comment of						

07-03364 Helen E. Parris

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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2	U	IJ	Í	i	5	6	4	

IEH E. Fallis		For State	uto 0: 10	ici yici ici	Certific	cate of	Death					Reg. No.			~
Physician		egistrar . Decedent's Name (First, Middl	e,Last)							- 1	Date of De Month	Day	Year		Time of Death 0253 hrs
edical Examin		Helen E. Parri									May 3, 2	007		(Darth	02001113
1		a. Facility Name (if not institution		et and number)		4	b. City, Tow		cation of	Death			. County of Anne Aru		
	н	3900 Germantown Ro					Edgewa	ter							less (State of
Funeral	5	. Social Security Number	6. Sex	7. Ag	e (In yrs. last b	oirthday)	If Under 1							I Foreign	lace (State or
Director	- 1	216-24-7601	1 M	2X F	79	9 Yrs.	Months	Days	Hours	Min.	4/20	/192	8	Count	<sub>r</sub> Maryland
	I.	Isual Residence of Decedent	1												out to the Oile Limite
any	_	0a. State 10b. County			10c. City, Tov	wn or Locati	on							- 1	0d. Inside City Limits
<u> </u>			Arun	de 1	Edges	water									Yes 2 X No
Aaryland 28a-f show	<u> </u>	0e. Street and Number					10f. Zip Co	ode				10g. Cit	tizen of Wh	at Countr	y?
or 28a-f sho	OΙ		m Dd				2	2103	7			i	USA		
a the		3900 Germantow		Was Deceden	(Franks II C	13 1//2	r Decedent	of Hisp	anic Origi	n? (Spe	cify Yes or	No-	14. Race		n Indian, Black,
n with	===	Marital Status     Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married Never Marrie		Armed Forces		If Y	es, specify (	Cuban,	Mexican,	Puerto F	Rican, etc.)		White	e, etc.	
deatl	<u>,</u>		1		XX No	1	Yes 2KX	No.	snecify:				Specify:	Whi	te
after al",	<u>a</u>		vorced If Ye	lates'	mlatad\ 16	Deceder	nt's Usual Oc			ind of wo	ork done	16b.	Kind of Bu	siness/Inc	dustry
ours natur xam	ᇗ	15. Decedent's Education (Sp				during m	ost of worki	ng life.	DO NOT	use retire	ed)				
5 72 h an "r	ompleted	Elementary/Secondary (0-12 1 2	)	College (1-4 or	5+)	Casl	hier						Food	Stor	e
og ithin	ĒĹ							11	8. Mother's	s Name	(First, Middl				
5-003 iled withi Hygiene I other th	ပ	17. Father's Name (First, Middl									irby				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	William F. Beh	lke	Drint	_	19h Mailin	g Address	(Street	and Num	ber or R	ural Route I	Number,	City or Tov	vn, State,	Zip Code)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relation					Hamb1				Riva,				
MD d 2 sho lth and n 27 is		Caroline Britt 20a. Method of Disposition	Mull	IIIS Dau	20h Pla		sition (Name				Date	200	. Location	- City or T	own, State
re, lan fikea	- 1	1 Burial 2 Cremati	on 3	Removal from S	state cre	matory or o	ther place)			E / 7	/2007	D <sub>0</sub>	rri doc	.nx7 i 1	le,MD
Pages ent of	-0	4 Donation 5 Other			Lake		Memori				/2007	_		_	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatite event,	-31	21. Signature of Funeral Servi	e Licensee			22.	Name and A	Address	of Facility	Har	desty	Fun	eral	Home	, P.A.
ini Ing Per Ber	ŀ	Just 1	11			12	Ridge	эту	Ave.	Ann	apoli	arrest s	D ZIA	eart	Approximate Interval
Physician		23a. Part I. Ent. the disease, failure. List only one cau	or complicat	tions that cause	ed the death. D	o not enter	the mode of	dying,	such as c	ardiaco	respiratory	arrost, c	110011, 01 11		Between Onset and Death
1edical		Immediate Cause (Final disea	_	oke inhala	tion										
aminer		or condition resulting in death	) Due	to (or as a cor	nsequence of):										
		Sequentially list conditions,	b												
	ner	if any, leading to immediate cause. Enter Underlying Cau	se	e to (or as a cor	nsequence of):										
	Examiner	(Disease or injury that initiate events resulting in death) La	d <u>. —</u>	e to (or as a co	nsequence of):	:									
ted d ansit	Ä		d.												
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be executed ours after death.  The law seriors After this certificate has been signed by the attending physician and fittled in by the funeral director, page 2 should be detached for use as the burial - transit	ical	UNPENDED  IF FEMALE:		MENDED											<u> </u>
50, te be sysicia buria	led	IF FEMALE:	<del></del>	23c. If yes, out	come of pregna	ancy							23d. Date		/ Day Year
876 tifica ing pl	2	23b. Was decedent pregnant i past 12 months?	n the	1 Live birth		_	Fetal death		Ectop	ic pregn	ancy	1	Month		Jay . Cu.
× 6 th cer trendi	<u>  ;</u>		Linknown	7	t at time of dea	atn 5	Other (Spec	cify)				- [			
Bo e dea the a	Physician/	Part II. Other significant con		9 Unknowr		sulting in the	e underlying	cause	given in F	Part I.	23e.	Did tobac	cco use cor	ntribute to	the cause of death?
O. hat th ed by letach	by P	Part II. Other significant col	ations co	ontributing to de	Bath but not to	33mmg m m	S 4.74-0-1, 11 S	,			1	Yes	2 No	3 Pro	bably 4 🗸 Unknown
ires ti sign lbe d	뒇										24a.	Was an	241	. Were a	utopsy findings availab
requiper : been should should	<del>š</del>	_										autopsy performe	ed?	prior to death?	completion of cause of
e law te has	Completed	1										Yes 2		1 🗸 Y	es 2 No
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the ras after death.	ပြ		dical					26.Plac	_		only one)				
is cer	B 8	examiner?		spital: 1 Inp	patient 2	ER/Outpation	ent 3 [	AOC	Other <sub>4</sub>		ing Home		esidence (		er: Scene
Phy Phy eral d	2			28a. Date of FOUND:	Injury	28b. Time	of Injury		jury at Wo		28d. Des	cribe hov : involv	w injury occ ed in res	urrea sidence	fire
n C nding h. Af	] [2]	1 Natural 5	Pending	14-11-2 20		FOUND: 0253 hrs		1	Yes 2	<b>∕</b> No	1				
Sion Attend r death. rector:	icat	2 🗸 Accident	nvestigation	28e. Place	of Injury - At ho	ome, farm, s	treet, factor	y, office	building,	etc.	or T	num Stat	10)		tural Route Number, C
Divi at or s afte at Dir	Certification:	3 Suicide 6	Could not be determined		Single Fam	nily					3900 Ge	rmanto	wn Road,	Edgewa	ter, MD
	_		n Physicia	n: To the best	of my knowled	ge, death or	curred at th	e time,	date and	place, ar	nd due to th	e cause(	s) and mar	ner as sta	ited.
To the Hos within 24 h	Medical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	Examiner:	On the basis of	examination a	nd/or invest	igation, in m	ny opini	on, death	occurred	d at the time	, date an	d place, ar	id due to t	he cause(s)
To t	Ped	29b. Signature and title of co		and manner sta	ted.				nse numb			1	29d. Date s	igned (M	onth, Day, Year)
	2	290. Signature and the or or		16	/			0.0	C.M.E.				May 3, 2	2007	
		7 Killer	Me	16. 9	Jan	us .	,								
0		80. Name and address of pe			of death (Item of Medical E	123a) Examinet	- 111 F	enn s	Street. F	Baltimo	ore, MD 2	21201			
8 CA	1	Theodore M. King					4								
	Stat		0 7 20	07	gistrar's Signat	K A	parke								
Reg	SIT	may_	0 1 20	-											
DHMH 17 Rev	1/200	1				ORIGI	NAL								

	1 - State Registrar	State o		Cer	tificate of	Death	- <del> </del>	Reg. No.		
sician	Decedent's Name (First, Middle,	,					2. Date of Do Month	eath Day	Year	3. Time of Death
dical	Vivian Arcada						May	4	2007	10:40 P
miner			ımber)		4b. City, Town, o		ath		ounty of Death	
	Union Hospital  5. Social Security Number		7 Ama /Im 1/00	la a t fairebut.	Elkt tf Under 1 Year		(S 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Cecil	1000
al or		6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		Months Days	Hours M	in. (Month, D	ay, Year)	Cou	
	177-10-4689 Usual Residence of Decedent		9	3			12-14-	1913	Penn	sylvania
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. tnside City Limi
ģ	Maryland Ce	ci1		Elkton						1 ☐ Yes 2X
Director	10e. Street and Number	CII		IKLOII	10f. Zip Code			10g. Citize	on of What Cou	ntry?
0	348 Ed Moore R	Coad			2192	1		Unite	ed State	es.
Funeral	11. Marital Status		edent Ever in U.	S. 13. V			(Specify Yes or Netro Rican, etc.)		. Race - Americ	can Indian,
		ed 1 Yes	edent Ever in U. orces? 2 📉 No	"	Tes, specify cubi	an, mexican, Pu Specify:	erto rican, etc.)	ì	Black, White, Specify: Whi	
d by	3   Widowed 4 □ Divorced	If Yes, G Year or I	Dates:		THIS ZELINO	<i>Зр<del>в</del>спу.</i>		3	<i>эрөспу</i> : WIII	LLE
etec	15. Decedent' (Specify only highes	's Education	)	16a. Deced	lent's Usual Occup	ation during most of v	vorkina	16b. Kind	d of Business/In	dustry
igu	Etementary/Secondary (0-12)	1	1-4or 5+)		kind of work done OO NOT use retired	d)	· · · · · · · · · · · · · · · · · · ·			
Completed				Но	memaker			d	Home	
Be	17. Father's Name (First, Middle, L					18. Mother's N	lame (First, Middle	e, Maiden S	umame)	
ို							nce C. Ho			
	19a. Informant's Name/Relationsh	nip (Type, Print)			•		Rural Route Numb			•
	Kenneth Pyle		005 0	-k		Road, E	1kton, Ma			
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 ☐Removal from	State	emetery, cren	sition (Name of natory or other place		Date	20c. Loca	ation - City or To	own, State
	4 □ Donation 5 □ Other (Sp	pecify)	R.T		d <sub>P</sub> Funera					Maryland
1	21. Signature of Funeral Service L	Licensee	1.				.T. Foard			
ToB	Kichard	J. Jo	o fre				, Rising		MD 2191	1
	23a. Part1. Enter the disease, or o shock, or heart faiture. List of	complications that	caused the deatlead	h. Do not ente	er the mode of dyir	ng, such as card	ac or respiratory	arrest,		Approximate Intervat Between
	tmmediate Cause (Final disease or condition	U	Auto	Mu	ocapel s	122	nection		1	Onset and Death
	resulting in death)	a Due to	s a conseq	uence of):	0011	111	10012			
	0									
ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(o. as a conseq	uence oi).						
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
		Due to	(or as a conseq	uence of):						
edical		d						- · · · · · · · · · · · · · · · · · · ·		
2	23b. Was decedent pregnant		itcome of pregna birth 2 ☐ Feta		Ectopic pregnancy	,		23	d. Date of delive	,
Physician/M	in the past 12 months?		nant at time of d		Other (specify)				Month	Day Year
hy	9 ☐ Unknown									
by		ns contributing to	leath but not res	utting in the un	nderlying cause giv	en in Part I.			,	he cause of death?
							- 10	Yes 2	\$No 3□Prot	oably 4 ☐Unkno
Completed							24a. Was	s an	24b. Were auto	ppsy findings availa
E							auto perf	ormed?	death?	2□ No
	25. Was case referred to medical					26. Place of D	eath (Check only		1 1 1 1 1 1 1 1 1	2010
0	examiner?	Hospitat:	Inpatient 2	ER/Outpatient	35 DOA Oth	00	Home 5 Res		□Other /Specif	€)
o Be	1 ☐ Yes 2 € No		of Injury	28b. Time ot	28c. Injur		28d. Describe			<i>,</i> ,
To Be	1 ☐ Yes 2 No  27. Manner of Death		nth, Day Year)	Injury		k/ Yes 2∐No				
To Be	1 ☐ Yes 2 No	g (Moi					28t Location	Street and	Number or Rura	al Route Number.
To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	g (Moi pation not be 28e. Plac	e of Injury - At ho	ome, tarm, stre	eet, tactory, office		Zov. Zoodiloii			
ertification: To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	g (Moi pation not be 28e. Plac	e of Injury - At ho ling, etc. (Specif	ome, tarm, stre	et, tactory, office		City or To	wn, State)		
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Certification: To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	g Amount be ined 28e. Place build g Physician: To the Examiner: On the	ling, etc. (Specify e best of my kno	y) wledge, death	occurred at the tir	me, date and pla	City or To	own, State)	nd manner as s lace, and due to	tated.
ertification; To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	g Amount be ined 28e. Place build g Physician: To the Examiner: On the	ling, etc. (Specify e best of my kno pasis of examina	y) wledge, death	occurred at the tir	pinion, death or	City or To	wn, State) cause(s) a date and p	nd manner as s lace, and due to signed (Month,	stated. o the cause(s)
Certification; To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 6 Could n determine  29a. Certifier (Check only one)	g Amount be ined 28e. Place build g Physician: To the Examiner: On the	ling, etc. (Specify e best of my kno pasis of examina	y) wledge, death	occurred at the tirestigation, in my o	pinion, death or	City or To	wn, State) cause(s) a date and p	lace, and due to	stated. o the cause(s)
Certification; To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig 2 Accident 3 Suicide 6 Could n determine  29a. Certifier (Check only one)  29b. Signature and title of certifier	g Physician: To the Examiner: On the and mai	e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	29c. Licens	pinion, death or	City or To	wn, State) cause(s) a date and p	lace, and due to	stated. o the cause(s)
Certification; To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig 3 Suicide 4 Homicide 6 Could in determine  29a. Certifier 1 Certifying (Check only one)  29b. Signature and title of certifier 30. Name and address of person v	g Physician: To the Examiner: On the and mai	e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	29c. Licens	e number	City or To	wn, State) cause(s) a date and p	lace, and due to	stated. o the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** M May 10. 2007 12:52 P Ida Pannebaker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, June 22, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖺 F 73 Unknown 218-76-1984 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County a or 28a-f show t be notified at 10a. State 1 ☐Yes 2√ No Director Prince George Forestville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with items 23a diner must b 7420 Marlboro Pike 20747 USA e filed within 72 hours after death val Hygiene.
other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. r than "natural", or item the Medical Examiner 1 ☐ Yes 22 ☐ If Yes, Give Year or Dates: 2XX No Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of and 2 should be UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Rosemary Mason / Guardian 6420 Allentown Road Camp Springs, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 5/14/2007 Clinton, MD. 4 Donatiop 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur of Funeral Service License ala 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death Parts. Enter the disease, or complica shock, or heart failure. List only one ns that caused the death. use on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 1 atral Freumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached fi P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performed' 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P safter death. I Director: After t d in by the funera 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

Registrar

Palmer MD 31. Date filed (Month, Day, Year) MAY 2 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of cep



29c. License number

D0055120

29d. Date signed (Month, Day, Year)

10 2007

07-03623 Waller V. Ruckee

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Ligan	101	100	4	ě	100	0		-

		I- For State Registrar		Certi	ficate of	Death				F	Reg. No.			
Physicia ledical Examir	n/	1. Decedent's Name (First, Midd Waller Vernon								Date of De Month May 11, 2	Day	Year	];	3. Time of Death 1725 hrs
		4a. Facility Name (if not institute 2910 Radius Rd.		umber)		4b. City, Tow	n, or Lo	pring	Death			County of D Ontgome		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1		If Under :		8. Date of B	irth(MM/DI			place (State or
Director		207-36-9108	1 <b>x x</b> M 2 F	5	9 Yrs	Months	Days	Hours	Min.	Oct.	1, 19		Coul	<sup>ntry)</sup> Virginia
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Locat	ion								10d. Inside City Limits
<u>*</u> 1	ō		ntgomery		Silver									1 Yes 2 XXNo
Maryl 28a-	Director	10e. Street and Number				10f. Zip Co					10g. Citize	en of What	t Count	ry?
th the Mary 23a or 28a notified at		2910 Radius I			1		902		2 / 2			USA		L. Carlo
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 N	12. Was De Armed F	ecedent Ever in U.S. Forces?		as Decedent 'es, specify (					10-	4. Race - A White, e		an Indian, Black,
after o	DY F	3 X Widowed 4 Di	vorced If Yes, Give Ye		1	Yes 2	<sup>K</sup> No	specify:				specify <b>Wh</b> :		
natur	eted t	15. Decedent's Education (Spe			16a. Deceder during m	nt's Usual Oc nost of workin					16b. Kir	nd of Busin	ness/In	dustry
36 in 72 l	plet	Elementary/Secondary (0-12)	College (	(1-4 or 5+)		Неа	- - Me	chan	ic			Go	1 f	Course
5-0036 Tled within 72 Hygiene. d other than the Medical	Comple	17. Father's Name (First, Middle				1100				First, Middle	, Maiden S			course
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2121 ould be fi ould be fi Mental s marked ic event,	2	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address	Street	and Numb	er or Ru	ral Route N	umber, City	or Town,	State,	Zip Code)
MD d 2 sho lth and n 27 is		Charles D. A	Anderson/S	Step-son	2910			ad,	Silv	zer Sp Date	ring,	MD .	209	02
or free free free free free free free fr		20a. Method of Disposition  1 X Burial 2 Crematic	n 3 😿 Removal		ace of Disposematory or of		ot cem	etery,	May	z 15	20c. Lo	ocation - C	ity or	own, State
Page Page ment c		4 Donation 5 Other 5	Specify:	Blai	r Memo		12.5			007				Pennsylvan
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than injury or other traumatic event, the Medical	Į	21. Signat e o Funeral Service	X 1/	Do.		Name and Ad								
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/Medical - - - - - - - - - - - - - - - - - - -	1	Immediate Cause (Final diseas	<sub>e a.</sub> Cirrhos	sis of liver										Death
		or condition resulting in death)	,	a consequence of): 1 abuse										
	ē	Sequentially list conditions, if any, leading to immediate		a consequence of):	:									
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executed an and al - transit	_	events resulting in death) Last	d	a consequence of):	-								_	
760, cate be executed physician and the burial - transi	n/Medical	X UNPENDED	X AMENDED	#23a-b,27,p <b>ME5-16-07</b>	perME, g	868, 6/	11/0	7 TT						
38760, rtificate be ing physic as the bur	Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes	, outcome of pregna	ancy							. Date of de	-	
certification	cian	past 12 months?	I I LIVE	birth gnant at time of deat	2 Fo	etal death ther <i>(Specif</i>	3 _	Ectopic	pregnan	су	'	Month	D	ay Year
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्र <del>व</del> केल	by Ph	Part II. Other significant cond	itions contributing	to death but not res	sulting in the	underlying c	ause gi	ven in Par	H.					he cause of death? ably 4 Unknown
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ords, aw requir	ple									aut	opsy formed?	pri	ior to c	ompletion of cause of
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seen is the funeral director, page 2 should	ဥ	1 ✓ Yes 2 No 27. Manner of Death		·	ER/Outpatien 28b. Time of			at Work?		28d. Describ		ry occurred		: Scene
nding Ph th. : After t	ion	1 Y Natural	(Mor	te of Injury hth, Day,Year)				es 2 🔃 I			,	•		
iSiC Atter er dea rector	icat		estigation28e. Pla	ace of Injury - At hor	me, farm, stre	eet, factory, o	ffice bu	ilding, etc	. 2			nd Number	r or Ru	ral Route Number, City
Divisior ipital or Attend ours after death heral Director:	Certification:	Odicide	uld not be ermined (Specif						or Town	, State)				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:			Physician: To the b	est of my knowledge	e, death occu	urred at the ti	me, dat	e and plac	e, and o	due to the ca	ause(s) and	manner a	as state	ed.
To th within To th	Medical		and manner					number	arroa at	tire tirre, da				oth, Day, Year)
	2	29b. Signature and title of certific	JUK	10			D.C.N				1	12, 200		, 564, 1001)
2			MY	you of death /ltext (	239)							,		
		30. Name and address of person Susan Hogan MD.	on who completed ca Assistant Med			nn Street,	Balti	more, N	ID 212	201				
St	ate	31. Date filed (Man II) Day, Year		egistrar's Signatur		0.000								
Regist		Mari T	0 5001	MARINE L	5 10									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARIE LYARD RENE APRIL 2007 30 10:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WHEATON MANOR CARE MONTGOMERY WHEATON 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/25/1930 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Days Min HAITI Yrs. Director 579-76-2973 77 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 TX Yes 2 □ No Director MARYLAND PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23a or ? 9317 WOODBERRY STREET 20706 HAITI Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 X Never Married 2 Married 1 □ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be DUPERON RENE TERENCIA ST.CLAIR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LOUIS SAINT-FELIX/NEPHEW 9317 WOODBERRY STREET, LANHAM, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State <u>o</u> = ₀ Department of Important: If I any Injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN CEM. 4 Donation 5 Dother (Specify) 05/05/2007 SILVER SPRING, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVENUE; 23a. Part1. Enter the disease, or complications that caused a shock, or heart failure. List only one ceuse on each line ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by CEREBRAL INFARCTION WITH HEMIPLEGIA 1 🗌 Yes 2 No 3 ☐ Probably 4 X Unknown DIABETES MELLITUS TYPE 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No DEMENTIA 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 Division or Vital Records,

Saltimore, Maryland 21215-0036

To the Hospital of within 24 hours at To the Funeral D

31. Date filed (Month, Day, Year) State Registrar 07

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

D52261

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MAY 1, 2007

ALAN R. SEGAL, M.D., 1900 FOREST GLEN RD. SILVER SPRING, MARYLAND 20910

Amend 6 per May 16, 2007

Baltimore, Maryland 21215-0036

6 per FI	)	Plea	se Type or	Print in B	lack Ind	delible Ink.	Ensur	re All	Copies A	re Le	gible.	
6, 2007 A	YY.	GSR For	State	of Maryland	d / Depa	rtment of H	lealth a	nd M	ental Hygi	ene		
		State Registrar			Cer	tificate of l	Death		Re	g. No. 2	007	1 16632
Dhominia		1. Decedent's Name (First, Middle	e, Last)						2. Date of Death Month		Year	3. Time of Death
Physicia /Medic	_	Cecilia Angela							Month 5/02	_		11:45a™
Examin	_	4a. Facility Name (If not institution				4b. City, Town, or		Death			unty of Deatl	
and the sheet of		Anne Arundel 1			6	Annapo1	is If Under 2	M Hre	9. Data of Birth	Anne	e Arun	
Funeral Director		5. Social Security Number 314–48–6593	6. Sex 1 ☐ M 2 <b>XX</b> F	7. Age (In yrs. la		Months Days	Hours	Min.	8. Date of Birth (Month, Day)	18		nplace (State or Foreign untry) <b>n10</b>
and w		Usual Residence of Decedent  10a. State 10b. County	_	10c. City	, Town or Lo	cation		-				10d. Inside City Limits
f sho	ō	MD Anne A	rundo 1	Ann	apolis	1						1 ☐ Yes 2 <b>2</b> ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 11 North Home1		11111	аротт	10f. Zip Code	1401		10	g. Citizen	of What Co	untry?
eath v	eral			cedent Ever in U.S	S. 13. V	Vas Decedent of H	ispanic Orig	in? (Spe	cify Yes or No-	14.	Race - Ame	rican Indian,
ter de	L L	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Fried 1 ☐ Yes	orces? \$√TXNo		Vas Decedent of H f Yes, specify Cuba		Puerto	Rican, etc.)		Black, White	
urs af	ρ	₩₩idowed 4 Divorced	If Yes, G Year or	live	_   1	☐ Yes <b>XX</b> No	Specify:			Spi	ecify: WI	nite
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d Mer narke	ဠ	19a. Informant's Name/Relations		<u> </u>	10h Mailin	g Address (Street						Zin Code)
and 2 sl salth and 2 is not 27 is refer traur		Jane R. Ciupek			11 Nor	th Homel		ve.	Annapol:	is, M	D 2140	01
of He		20a. Method of Disposition 1 ☐ Burial 2 【XCremation	3 □Removal from	o State	emetery, crer	sition (Name of natory or other plac	ce)	_			ion - City or	
Pagiment ment: tant: jury o		4 □ Donation 5 □ Other (S		Met		ematory	1 '	/7/2			more,	
ermit Depart Mpor ny in		21. Signature of Funeral Service	Licensee	11		Name and Addre						F.A.
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		23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause on				ig, suoii as c	oararao c	i respiratory arre	, ,		Approximate Interval Between Onset and Death
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ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregna birth 2 ☐ Feta	Ideath 3	Ectopic pregnanc	у			23d	. Date of del Month	livery Day Year
The law requires that the death certificate be ate has been signed by the attending physicis bage 2 should be detached for use as the bu	Physician/Medica	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4⊔Pre 9□Uni	gnant at time of de known	eath 5L	Other (specify) _						
that the	Ph	Part II. Other significant conditi	ons contributing to	death but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did tol	acco use	contribute to	the cause of death?
signe d be	d by								1 □ Y	es 2 <mark>1</mark>	No 3□P	robably 4 ∐Unknown
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he lav e has ige 2	ф								autops perfort	ned?	prior to death?	completion of cause of
sician: The law certificate has t irector, page 2 s		25. Was case referred to medica	al				26 Place	of Death	1□ Yes ∩ (Check only on	2 <b>2</b> No e)	1 ∐Yes	s 2□No
rsician: s certific lirector,	o Be	examiner? 1 ☐ Yes 2 █ No	44 44 4	Inpatient 2□	ER/Outpatier	nt 3□ DOA Oth	ner:		me 5☐Reside		Other (Spe	ecify)
Attending Physician: r death. ector: After this certifics by the funeral director, I	n: To	27. Manner of Death	28a. Da	e of Injury	28b. Time o				28d. Describe ho			
ath. rr. After te funera	atio	Z III Accident	igation	Jilii, Day Tear)	injury		Yes 2 □ N	No				
I or Atte after de. Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningd   20t. Fla	ce of injury - At ho Iding, etc. (Specif	ome, farm, str y)	eet, factory, office			28f. Location (Si City or Town		lumber or R	ural Route Number,
To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physician: To the sand me	he best of my kno basis of examina anner stated.	wledge, deat tion and/or in	h occurred at the ti	ime, date an opinion, dea	d place, ath occur	and due to the c red at the time, c	ause(s) an late and pl	nd manner a ace, and du	s stated. e to the cause(s)
To the within 2 To the complei	Me	29b. Signature and title of certific	nd Bech	ryp		29c. Licens	se number Y 605	2	2	9d. Date s	signed (Mon	th, Day, Year)
ملاه ۵		30. Name and address of person	who completed ca	use of death (Item 2001 W.4	1 23a) (Type,	Print) Von hum	a	nha	polos			

204 State

Registrar

Stock a Blech, the

MAY 0 7 2007

32 Registrar's Signature

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of N	aryland	-	rtment o			Mental Hy	giene 0	)7	16633
	Dhysisi		1. Decedent's Name (First, Middle, Las	st)						2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		GRANT LEE ROSIER							MAY	03 20	207	6:41
	Examin	er	4a. Facility Name (If not institution, give	1 .		- 0	4b. City, To	wn, or Lo	cation of Dea	h	4c. County	Death .	100
	Euroval	-	5. Social Security Number 6. S	odical.	onto	birthday)	If Under 1 Y		Under 24 Hrs		rth	9. Birthp	lace (State or Foreign
	Funeral Director			M 2 F	66	Yrs.	Months D	Days H	Hours Min	MARCH D	25,1941	MAR	place (State or Foreign
_	p >		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation					1	Od. Inside City Limits
	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f show he Medical Exercitor must be notified at	by Funeral Director	MARYLAND CHARL	ES	LA PI		,						1 X Yes 2 □ No
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	/Medical Examiner		1 death)	Due to (or a	is a consequer	of):	0 0	1. 0	r.		liseas		
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3760,	2 2 2	Icai		d									
P.O. Box 68	ertifica ling pt	by Physician/Med	IF FEMALE:									-	
90	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal de	ath 3	Ectopic pregi				23d. Date Mor	e of delive	ery Day Year
Ö	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at time of deat	n 5_	Other (speci	my)					
	that the by determined by	y Ph	Part II. Other significant conditions of	ontributing to death	but not resultin	ng in the ur	nderlying caus	se given i	in Part I.	23e. Did	tobacco use contr	ibute to tl	he cause of death?
rds	quires n sigr									1 🗆	Yes 2□No	3 Prob	pably Athknown
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ita	artifice ctor.	Be	25. Was case referred to medical examiner?					2	6. Place of De	ath (Check only			
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Ę.	Jing P	lon:	27. Manner of Death  → Natural 5 Pending	28a. Date of Ir (Month, I	Day Year)	b. Time of Injury	M 28c	. Injury at Work?	t s 2 □No	28d. Describe	how injury occurre	Эď	
Division of Vital Records,	death death ctor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not b	e Gen Blace of	njury - At home	a farm str			S 2   140	28f Location	(Street and Numbe	er or Run	al Route Number
Ď.	after after Direct	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	o, rairii, 3(ii	out, lactory, o	/// CO			wn, State)	,, 0, 1,0,0	
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificete has been signed by the ettending ph completely filled in by the funeral director. page 2 should be deteched for use as the	dical C	29a. Certifier Certifying Pt (Check only one)	sysician: To the be niner: On the basis and manner	of examination	and/or inv	vestigation, in	my opini	ion, death occ	urred at the time	date and place a	and due to	o the cause(s)
	To the	Med	29b. Signature and title of certifier	3			29c. L	icense n	umber		29d. Date signed	(Month,	Day, Year)
	->-0		· /					04	573	7	5/1	4/0	7
	7		30. Name and address of person who	completed cause	f death (Item 2	3a) (Type,	Print)		-	2.4	. 1 0	. (	1
v <u></u>	DB1		N. Jayantha	am n.	3328	Old	Wash	ing	ton k	d. Wa	LdoRt	Ma	1. 20603
	Sta Registr		31. Date filed (Month, Day, Year) MAY 08	2007 32. R/gi	strar's Signatur	y de	book						Day, Year) 7 1. 20603
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 30 2007 **Physician** 1425 MIKHAIL SURIKOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Wash. Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov . | 13,1910 5. Social Security Number 7, Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1**⊠** M 2□ F 96 Russia Director 230-51-5416 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Rockville MD Montgomery 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20853 U.S.A. 12630 Veirs Mill Road #416 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after oal Hygiene. I Other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fine and Mental F Surikov Unknown Semen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 Well House Ct Germantown, MD 20874 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau once. Avgust Vaynburg- Son 20b. Place of Disposition (Name of cemetary, crematory or other place)
Parklawn Mem Pk 20a. Method of Aisposition 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from 5/2/07 Rockville, MD 5 ☐ Other (Specify) re Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signat 46 N. Washington St Rockville, MD20850 23d. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 Days **PNEUMONIA** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physiclan and the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical e attending ph d for use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.0. been signed by the should be detached 9ŪUnknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed certificate has been rector, page 2 shoul Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) funeral dir P 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30946 April 30, 2007

State Registrar

31. Date filed (Month, Day, Year)

Kris E.

MAY 07 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kris E. Kahn, MD 6121 Montrose Rd Rockville, MD 20852

Mary P. Spiro  May P. Spiro  May P. Spiro  May P. Spiro  May A. Facility Name (i' not institution, pive street and number)  40. City, Town or Location or Death  Mary F. Spiro  May A. Facility Name (i' not institution, pive street and number)  5. Social Security Number  6. Sex  May A. Hours  Man. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		Registrar				ertificate of	Dealli		Reg. No.		
Mary P. Spiro  Mary Indiana Spiro Chapter  Mary Indiana Sp			e (First, Middle, La	ast)						Vaar	3. Time of Dea
## A Facility Name of Front Assistance, your street and number  ## A Facility Name of Front Assistance, your street and number  ## A Facility Name of Front Assistance of December  ## A Facility Name of Front Assistance of December    10		Mart D	. Spiro								3:50 P
Social Security Number   Case   Cas		A. P. 10 AL 11	f not institution, gi	ive street and number)		4b. City, Town,	or Location of De	ath	4c. C	ounty of Deal	th
Social Security Number   Case   Cas		Manor Ca	re-Chevv	Chase		Che	vv Chase			Monta	omerv
Table   Tabl	al		umber 6.	Sex 7. Age	, ,	Months Day	r   If Under 24 Hi	S. 8. Date of Bir	th ay, Year)	9. Birt	thplace (State or Fo.
10s. State   10b. County   10c. City, Town or Location   10d. Taylor Only   1   10d. Taylor of What County   1   10d. Taylor Only   1   10d. Taylor of What County   1   10d. Taylor of What County   1   10d. Taylor of What County   10d. Mark State   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of What County   10d. First of Business   10d. Taylor of Business   10d. Ta	or		0480	1 M 2 2 2 F	84 Yrs.					23 Pe	nnsylvani
Vincent Puglin   Sale   Spring   Spring   Sale   Spring   S					10c City Town or	Location					10d Inside City Li
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Vincent Puglin    Sale   Informatic Name Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Name; City or Town, State, Zip Code)	Į,	11. Marital Status	om M	Armed Forces?		If Yes, specify Cu	iban, Mexican, Pu	orto Rican, etc.)	)-		
Vincent Puglin   Selection   Selection   Puglin   Selection   Selection   Puglin   Selection   Selectio			_	If Yes, Give	40	1 ☐ Yes <b>2</b> ☐ N	o Specify:		S	Specify with i	+0
Vincent Puglin  199. Maling Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)  Mary Louise Spizo/Daughter  20a. Method of Disposition   Removal from State   107/13   Gatavecod   Ny article   Silver Spring   Np 2 0/3    20a. Method of Disposition   Removal from State   107/13   Gatavecod   Ny article   Silver Spring   Np 2 0/3    20a. Method of Disposition   Removal from State   Np 2 0/3    20a. Method of Disposition   Removal from State   Np 2 0/3    20a. Method of Disposition   Name of   Name   Na				<u>. L</u>	16a De	cedent's Usual Occ	unation				
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Mary Louise Spirr/Daughter  20a Method of Disposition    Spirral 2 (Spremation 3   Spennoval from State	12			(Type Print)	10h M	ailing Address (Ctra					Zin Code)
Burst   @Cremation   Signature of Funeral Service Licensee   Part   Deportment   Deportment   Part   Deportment   Dep	31	13a. Illionnain 3 14a	amer telationship	(Type, Thin)							
Bural 2 @Cremation 3   Removal from State				/Daughter	20b. Place of Dis	U3 Gatewo	od Avenu	e Silve	r Spr	ing, M	D 20903
23a. Part 1. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  But the first and such arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  But the first arrest.  Approximate interval Between the mode of dying, such as cardiac or respiratory arrest.  But the first arrest.  Approximate interval Between the mode of dying, such as cardiac		1 🗆 Burial 2 [	Cremation 3		cemetery, c	rematory or other p			200. 200	ation only or	iomi, olalo
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Sequentially list conditions.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part III Other significant conditions contributing to the cause of death part of the cause of death part of the cause of death part of the cause of death part of the cause of death part of the cause of death part of the cause of death part of the cause of death part of the cause of death part of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c	a	do	us 5	Long						r Spri	ng, MD 2
a. Due to (or as a consequence of):    Due to (or as a consequence of):		23a. Part1. Enter the shock, or hea	he disease, or cor rt failure. List only	mplications that cause on each lin	the death. Do not	enter the mode of di	vina cuah ac aardi				Annrovimate
Sequentially list conditions   Sequentially list conditions	n	Immediate Cause (			10.		ying, such as cardi	ac or respiratory a	irrest,		Interval Between
Sequentially list conditions				n dy	\			ac or respiratory a	rrest,		Interval Between
The female is a consequence of the female is sufficient conditions contributing to death but not resulting in the underlying cause given in Part I.    Continue of the conditions contributing to death but not resulting in the underlying cause given in Part I.		disease or conditio			anced			ac or respiratory a	irrest,		Interval Between
mat initiate a vents resulting in death) Last    The FEMALE   23b. Was decedent pregnant in the past 12 months?   1   1 ves   2   No   3   Probably   4   2   No   4   Norsing Home   5   Residence   6   Other (Specify)   1   Yes   2   No   Norsing Home   5   Residence   6   Other (Specify)   2   Norsing Home   5   Residence   6   Other (Specify	r	disease or condition resulting in death)	n (	Due to (or as	anced			ac or respiratory a	irrest,		Interval Between
d.    IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Ye   24b. Was an autopsy performed?   1   Yes   2   No   24b. Was an autopsy performed?   1   Yes   2   No   24b. Was an autopsy performed?   1   Yes   2   No   25b. Place of Death   1   Live birth 2   ER/Outpatient   3   DDA   Cther   4   Nursing Home   5   Residence   6   Other (Specify)   27b. Month 2   28d. Describe how injury occurred   1   Yes   2   No   27b. Month 2   28d. Describe how injury occurred   28d. Describe how injury occurred   28d. Location (Street and Number or Rural Route Number   28d. Describe how injury occurred   28d. Location (Street and Number or Rural Route Number   28d. Describe how injury occurred   28d. De	н.	disease or condition resulting in death)	n (	Due to (or as	ancod a consequence of):			ac or respiratory a	rrest,		Interval Between
FFEMALE: 23b Was decedent pregnant in the past 12 months?   1   yes 2   No 9   Unknown   1   Unknown   1   Unknown   23d. Date of delivery   Month Day Yes   23d. Da	Н.	disease or condition resulting in death)	nditions, introductions injury	Due to (or as	ancod a consequence of):			ас от гезрпатогу а	rrest,		Interval Between
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1   Yes   2   No   3   Probably   4   Qun	edical Examiner	disease or condition resulting in death)  Sequentially list confidence in any, leading to find cause. Enter Under Cause (Disease or that initiated events resulting in death) L	nditions, introductory injury , ast	Due to (or as a b. Due to (or as a d. Due to (or as a d. 23c. If yes, outcome	a consequence of): a consequence of): of pregnancy	Deme	ntia	ас от гезрпатогу а			Interval Betwee Onset and Dea
25. Was case referred to medical examiner?  1   Yes   2   No   3   Probably   4   Qun    24a. Was an autopsy performed? performed?   1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No   No    26. Place of Death (Check only one)  27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No    29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)	edical Examiner	disease or condition resulting in death)  Sequentially list confidence in any, leading to find cause. Enter Under Cause (Disease or that initiated events resulting in death) L	nditions, strandate rhying injuryast	b. Due to (or as a b. Due to (or as a d. Due to (or as a d. Due to for a d. Due to fo	a consequence of):  a consequence of):  a consequence of):  of pregnancy 2 □ Fetal death	ORM ()	ntia	ac or respiratory a			Interval Betwee Onset and Dea
24a. Was an autopsy performed? 1   Yes   2   No   3   Probably   4   Young   24a. Was an autopsy performed? 1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 1   Yes   2   No   1   Yes   2   No   26. Place of Death (Check only one)  27. Manner of Death   28a. Date of Injury (Month, Day Year)   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work? 29a. Certifier (Check only one)  29a. Certifier (Check only one)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Check only one)   29a. Certifier (Check only one)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Check only one)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)	edical Examiner	disease or condition resulting in death)  Sequentially list confidence in any, leading to find cause. Enter Under Cause (Disease or that initiated events resulting in death) L	nditions, strandard rying injury sast	b. Due to (or as a b. Due to (or as a d. Due to (or as a d. Due to for a d. Due to fo	a consequence of):  a consequence of):  a consequence of):  of pregnancy 2 □ Fetal death	ORM ()	ntia	ас от гезриатогу а			Interval Betwee Onset and Dea
25. Was case referred to medical examiner?  1	Physician/Medical Examiner	isease or condition resulting in death)  Sequentially list confliction of any, leading to find cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE:  23b. Was decedent in the past 12  1	nditions, introductor trying injuryast	Due to (or as a b.  Due to (or as a d.  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a consequence of):  a consequence of):  of pregnancy 2 ☐ Fetal death time of death	OEMP	nti a		23	Month	Interval Betwee Onset and Dea
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1 Natural 2 Accident 3 Suicide 4 Homicide   5 Pending investigation 3 Suicide 4 Homicide   5 Pending investigation 6 Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of City or Town, State)   29a. Certifier (Check only one)   29d. Certifier (Check only one)   29d. Date signed (Month, Day, Year)   29b. Signature and title of certifier   29b. Signature and title of certifier   29b. Date signed (Month, Day, Year)   29c. License number   29d. Date signed (Month, Day, Year)	Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conflam, lauding to fill cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, introductors, introductors, introductors, introductors, introductors, interest to pregnant months?	Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as	a consequence of):  a consequence of):  of pregnancy 2 Fetal death time of death  ut not resulting in the	3 Ectopic pregnant 5 Other (specify)	given in Part I.	23e. Did t 1 [] 24a. Was auto perfo 1 [] Yes	23 tobacco use Yes 2  an psy rmed? 2 No one)	Month  e contribute to  No 3 pr  24b. Were au prior to death? 1 Yes	livery Day Year or the cause of death robably 4 2 Unkr utopsy findings ava completion of causes
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list conflictions are cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, strandard rhying injury	Due to (or as a b.  Due to (or as a c.)  d.  23c. If yes, outcome a c.  1	a consequence of):  a consequence of):  a consequence of):  of pregnancy 2   Fetal death time of death  ut not resulting in the  y year)   28b. Time Injur  of my knowledge, de examination and/or	3 Ectopic pregnants of their (specify)  a underlying cause of their street, factory, office their investigation, in my	26. Place of Dother:  A Nursing uny at lork?  Yes 2 \ No e	23e. Did t  1  24a. Was auto perfc 1 Yes eath (Check only of the control of the c	tobacco use Yes 2  an psy ormed? 2 No one)  dence 6 how injury  Street and wn, State)  cause(s) a date and p	Month  e contribute to  No 3 Pr  24b. Were au   prior to   death? 1 Yes  Other (Spe   occurred  Number or Re  and manner as blace, and due	Interval Betwee Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset On
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Examiner -transit The law requires that the death certificate be executed ing physicien ar s as the burial-ti Division of Vital Records, P.O. Box 68760, use ō detached 2 signed t page 2 this certificate rector, ₽ funeral or Attending after death.

Director: Af
d in by the fu Hospitel within 24 hours a

Physician/Medical Examiner Completed by Be 은 Medical Certification:

**Physician** 

/Medical

**Examiner** 

Director

**Funeral** 

Director

item 27 is marked other then "netural", or items 23s or 28s-f show other traumatic event, if a Medical Exeminar must be notified at

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

s 1 and 2 should be filed within if Health and Mental Hygiene.

permit. Pages i Department of F Important: If ite any injury or oti once.

**Physician** 

/Medical

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier haver 5/2/07 D28656

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Ravi Passi, M.D.

0 7 2007

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

8609 Second Ave, #404B, Silver Spring, MD 20910

State of Maryland / Department of Health and Mental Hygiene U U / 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician**  $p^{\,\mathsf{M}}$ May 4, 2007 6:32 Siege1 Ude11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 3602 Tarkington Lane If Under 1 Year If Under 24 Hrs. Months Days Hours Min. JAN 26, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Months 1918 New York Yrs. 89 **Director** 133-03-4198 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 😾 No Directo Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23e or United States 20906 3602 Tarkington Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced naturai 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Menta! Hygiene. ont: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Health Food Business Owner 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Siegel Gorden Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11161 Yellow Leaf Way, Germantown, Maryland 20876 Juline Glaz / Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 🖫 Removal from State in ury or Life Legacy Foundation 5/5/2007 Tucson, Arizona permit. Page Department of Importent: If any injury or \* 4 XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. M00956 933 Gist Ave., LL, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. CONGESTIVE HEART FAILURE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Filler Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed this certificate has been al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Exeminer: On the basic examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manifer stated. (Check on! re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signal MAY 4, 2007 D0064615 1+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENEVIEVE WROBLEWSKI, M.D., 1355 PICCARD DRIVE, ROCKVILLE, MARYLAND 20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 07 2007

SIEGEL, JULUS

ROBERT PRENICIO SUBJECT  ROBERT PRENICIO SUBJE			1 - For State Registrar	State of Ma	aryland / Depa		t of H	ealth and		ntal Hyg		_	1 16	5638
Robert Francis Seubert Prancis Seubert Prancis Seubert Prancis Seubert Prancis Seubert Prancis Seubert Prancis Seubert				st)					2.	Date of Deat	h		3. Time	of Death
Social Security Number    Security Security Number   Security Security Number   Security Security Number   Security Secu	/Medi	cal				4b. City,	Town, or	Location of De			4, 2007 4:20			
Social Security Number    Security Security Number   Security Security Number   Security Security Number   Security Secu			Holy Cross Hosr	ital			Si	lver Sr	arin	ıa		Montgo	merv	
STAR_SCALAZA   Start	Funeral		5. Social Security Number 6.	Sex 7. Ag	(In yrs. last birthday)		1 Year	If Under 24 H	rs. 8.	Date of Birth	Year)			e or Foreigr
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College (1-40 5)   College (1-	or its	Ē	1 Never Married 2 Married	1x Yes 2 □ N	lo				allo uic	an, etc./			e, etc.	
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State  D61768  May 5, 2007  30. Name and address of person of completed cause of death (Item 23a) (Type, Print)  Fabienne Santel, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910  State  31. Date filled (Month, Day, Year)  2007	n: T licete r, pa									1 ☐ Yes 2	No No	1 🗌 Yes	2□ No	
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Registrar MINI V 2007 Page 15 December 1			31. Date filed (Month, Day, Year)	007 32 dégistr	ar s Signature	and to	9							

Certificate of Death Reg. No. 🧲 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARTINA RUTH SOLLIDAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LANHAM DOCTOR'S COMMUNITY HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🔽 F 62 NOV 25, 1944 Director 578-58-9727 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show ner must be notified at Director MARYLAND PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20715 U.S.A. 4006 CROYDON LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 7 is marked other than "natural", or iten traumatic event, the Medical Examiner and 2 should be filed within 72 hours after eath and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CUSTOMER SERVICE REPRESENTATIVE 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be **EUGENE** GLADYS WHITE CORRODO မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. 4006 CROYDON LANE, BOWIE, MARYLAND AARON WALLACE SOLLIDAY/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition ALEXANDRIA, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State METROPOLITIAN CREMATORY 5/6/2007 VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co is quence of): **Examiner** Sequentially list conditions, in cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician for use as the buris Physician/Medical

law requires that the death certificate be executed o σ. Division or Vital Records, or Attending To the .
within 24 hour.
- the Funeral Dite.

signed by the a

has

certificate

After t

death Director:

page

Unkern IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2N No 24a. Was an autopsy perform 1□ Yes 2 3 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of Natural 5 Pending investigation Injury 1 TYes 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and mariner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

WASHINGTON D.C

10d. Inside City Limits

1 X Yes 2 No

4c. County of Death

PRINCE GEORGE'S

14. Race - American Indian

WHITE

20715

Approximate Interval Between Onset and Death

Black, White, etc.

20715

Specify:

GIANT

FOODS

77

State Registrar

31. Date filed (Month, Day, Year) MAY 0 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene ( ) 0 7 6 6 4 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				Please	Type or Print in				-		•		
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4   Donation   Colonier (Specify)   Paryland Veterans Centerry   05/08/2007 Crownsyille, Maryland   22   Name and Address of Facility   George P. Kalas Funeral Home   2973 Solomons Island Rd., Edgewater, ND 21037	א ס	Hygid other		17. Father's Name (First, Middle, Last	)	ртс	CCI OIII					rpmerrc	
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Physician (Modical Examiner  23a. Partil: Enter the disease): complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate and another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate another than the mode of dying, such as cardiac or respiratory arrest.  Approximate and than the mode of dying, such as cardiac or respiratory arrest.  Approximate and such as a consequence of):  4. Due to (or as a consequence of):  5. Due to (or as a consequence of):  5. Due to (or as a consequence of):  6. Due to (or as a consequence of):  6. Due to (or as a consequence of):  7. Due to (or as a consequence of):  8. Due to (or as a consequence of):  9. Due to (or as a consequence of):  9. Due to (or as a consequence of):  10. Due to (or as a consequence of):  11. Due to (or as a consequence	Ē	rages lent of nt: If I		1 Burial 2 ☐ Cremation 3 ☐	Tueunovai iroin State				/08/2007	Crov	vnsville	. Marvland	
Physician Medical Examiners  Physician Medica	Dalt	Departm Departm Importa eny inju		21. Signature of Funeral Service Licer	1599		22. Name	and Address of Facility	George P.	Ka1	Las Fune	ral Home	
Due to (or as a consequence of):    Sequentially ist conditions, if anyl, leading to immediate quies. Enter Underlying in the inflated events in the post 12 months?		bicentan		23a. Pan . Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximat									
Sequentially lat conditions, as a consequence of light of the cause of the control of the contro		/Medical			Due to (or as a cor	nsequence of		NUT COT CC	<u> </u>	26		1142.	
The standard events of the part of the par			iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cor	sequence of	f):						
Section   Control of the control o	'n	be executed icten and purial-tran	700	that initiated events	CDue to (or as a cor	nsequence of	f):		****				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes 2   No 3   Probably 4   Unknown	00	p phys	edic		d								
The property of the property o	O. DOX	ne deain cert the ettending thed for use a	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							,	
25. Was case referred to medical examiner?    Yes   2   No		signed by be detact	by Ph										
25. Was case referred to medical examiner?  1   Second Death   Check only one    26. Place of Death   Check only one    27. Marny of Death   1   Natural   2   No.    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?    27. Marny of Death   1   Natural   2   No.    28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No.    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No.    28b. Place of Injury   28c. Injury at Work?   1   Yes   2   No.    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28d. Describe how inj		been s	eted	173 1120 11	24a. Was an autops performed						10000		
27. Manny of Death   Natural   Natur										psy ormed?_	prior to completion of cause of death?		
27. Many of Death 1  Natural 2  Accident 3  Suicide 4  Homicide 28a. Date of Injury M	=	s certif	100	examiner?	Hospital: Other								
29a. Certifier (Check only one of control of the cause of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one of control of the cause of the ca	5 1	er th	tion: T	27. Manual of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Ti	me of jury	28c. Injury at Work?					
29a. Certifier (Check only of the Dasis of Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only of the Dasis of Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and the of certifier (Check only of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Month, Day, Year)  30. Name and address (Month, Day, Year)  30. Name and address (Month, Day, Year)  31. Signature and the of certifier (Check only of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Month, Day, Year)  30. Name and address (Month, Day, Year)  30. Name and address (Month, Day, Year)	DIVIS	efter deal	ertifica	determined 200. Flace of injury - Actionie, famil, Street, factory, office 201. Location (						Street al	Street and Number or Rural Route Number, vn, State)		
30. Name and address of death (Item 23a) (Type, Print)  WARRING HANDIAN 120 SPEER (HESTERTIUM MD 21620		Prospite 24 hours Funeral stely filled		(Check only 2 Medical Exam	niner: On the basis of exam	knowledge, mination and	death occurre for investigation	d at the time, date and pl on, in my opinion, death o	ace, and due to the ccurred at the time,	cause(s date an	s) and manner as d place, and due	s stated.  to the cause(s)	
30. Name and address of death (Item 23a) (Type, Print)  WARRINAN 120 SPFER (HESTERTIUM MD 21620	;	within To the	Me				2	9c. License number	Ţ	29d. Da	ite signe (Mont	h, Day, Year)	
30. Name and address Completed cause of death (Item 23a) Type, Print)  ABORICH SHANDIAN 120 SPEER (HESTERTIUM MD 21620	'		1	Toka	Um m	<b>7</b> ,		D36054		5	14/0-	7	
	١	H1 5X		30. Name and address Am o	completed cause of death	(Item 23a) S	PFE	2 CHESTE		1	no 21	620	
State 31. Date filed (Month, Day, Year) 32. A gistrar's Signature Registrar MAY 0.7 2007				31. Date filed (Month, Day, Year)	32. A gistrar's S	Signature	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) May 2007 **Physician** Margaret Lorraine Schlagle 3:34A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park
If Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital Prince Georges 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2/□ F 78 Director February 23,1929 184-20-0685 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1√2 Yes 2 No Charles MD La Plata Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 104 West Hawthorne Drive 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone operator Federal Govt. permit. Pages 1 and 2 should be filled will Department of Health and Mental Hyglen. Important: If Item 27 is marked other tha any injury or other traumatic event; the x once. the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thompson Beatrice Orner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Schlagle/Husband P.O. Box 155, La Plata, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Brinsfield-Echols Crem.5/8/07 4 □ Donation 5 □ Other (Specify) Charlotte Hall,MD M01458 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Juneral Service Ligense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, ir any, reading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (or as a consequence of attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) by the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【 No 24a. Was an page 2 autopsy has certificate 1□ Yes Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Appatient 2 ER/Outpatient 3 DOA 2 this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral or 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Year) Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. or Vital Records, Division

State

Registrar

29a. Certifier

901

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKOUS

Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Mark Turco, M.D

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ALVIN STROTHER 10-2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER GEORGA PRINCE CLINTON If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 15 M 2 F Director 217-42-9824 62 Feb.19,1945 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 TyYes 2 No Director Md. PG District\_Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6602 Calvary Place 20747 United States Funeral filed within 72 hours after death Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 No If Yes, Give 1964 — Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 Widowed 4 Divorced "natural", 1984 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Strother Mary Clark ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State John Strother/brother 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cem. 5/18/07 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Synature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 day **Physician** Due to (or as a consequence of). /Medical Examiner 4 Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-transit renal acute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month signed by the at 1 be detached for 5 Other (specify) ☐Yes 2 ☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metaholic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pending 24a. Was an autopsy performed) at VA 2 No 2 No semile Heart disease or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2D NO 1 ☐ Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) M. D DO63183 07 V-Kerman

State Registrar

771

31. Date filed (Month, Day, Year) MAY 2 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD-20735

CHINTON-

ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 15<sup>Day</sup> **Physician** 2007 11:35P.™ Andrew Styka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City 8400 Ivy Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days **X** M 2□F Yrs April26,1922 Director 85 096-28-0939 Poland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes ¾☐ No Funeral Director Towson Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28 W. Allegheny Ave. #1505 U.S.A. 21204 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Coun<sub>tv</sub> 5+Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wanda Engelman Adam Styka ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28 W. Allegheny Ave. #1505 Towson, MD. 21204 <u>Maria G. Styka/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/17/07 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 6009 Harford Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meso Theliome **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-ransit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ 27. Man r of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

5

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ammling

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

516

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

North Rolly Road Suite 208

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) D2007 MAY 2, **Physician** 10:00A M TYREE **JAMES** REUBEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Shady Grove Adventist Hospital Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3 , 1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** NewYork 84 081-16-1142 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more or 28a-f show once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Germantown ¥⊓Yes 2 No MD Montgomery Director 10g. Citizen of What Country? #218 10f. Zip Code 10e. Street and Number U.S.A. 20874 21000 Father Hurley Blvd Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛂 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Pryor George W. Tyree ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21000 Father Hurley Blv#218 Germantown 7 MD 20874 19a. Informant's Name/Relationship (Type. Print) Mary Tyree- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition N Buria 2 ☐ Cremation 3 KRemoval from State . Hope Cemetery 5/8/07 Hastings, NY 4 □ Donation 5 □ Other (Specific) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service 246 N. Washington St Rockville, MD20850 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oneumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate in a leading to immediate in a leading to list any leading to the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I s been signer should be d Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s 1□ Yes 2√No To the Hospital or Attending Physician: within 24 hours all er death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natura! 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier J. Mistry MID May 2, 2007 D59738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MD 20850 T. Mistry 9901 32 egistrar's Signature 31. Date filed (Month, Day, Year) State 2007 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 01, May 2007 7:10 J. Turska /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1⊠M 2□F 82 Yrs. June 24, 1924 Maryland 385-16-4991 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20882 23313 Woodfield Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ত্র Yes 2 □ No If Yes, Give Year or Dates: 1946-49 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No <sup>Specify:</sup> Caucasian Specify. ş 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Science Chemical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Alice Martin Charles Turska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23313 Woodfield Road, Gaithersburg, Maryland 20882 Item 27 Health Paul Turska / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Iter any Injury or oth 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/07/2007 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Ligensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Eter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Onset and Death Immediate C use (Final disease or condition resulting in death) **Physician** days pneumonia /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown cate has been signed by a page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation To the moor after death.

Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier J. Mistry MD May 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alicia T. Mistry 99() | Merlin 9901 Medical Certer Brive Rock-ville, MB 20850 32. istrar's Signature 31. Date filed (Month, Day, Year) State 07

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** TURNER ELIZABETH DORIS 11:11 A.M MAY 15 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 8. Date of Birth (Month, Day, Yea FEB 15, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) Months Davs Hours 1 □ M 2 1 F 1935 MARYLAND Director 214-32-4987 72 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a. State 10b. County 10d Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director FREDERICK SABILLASVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21780 U.S.A. 17050 SABILLASVILLE RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 XWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 8 and Mental Hygi is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ IRVIN JOSEPH WETZEL RITA ETTA MANNING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1750 SABILLASVILLE RD., SABILLASVILLE, MD. 21780 DAVID R. TURNER, III/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State FRIENDS CREEK CEMETERY 5/18/07 EMMITSBURG, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOCRYCINOWO /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Dia and Due to (or attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the detached 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autonsy performed? certificate Yes 2 X No 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 2 1 🗌 Yes 1 Inpatient 2 K ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending Physicians val or Atto.

Justs after death.

-rai Director: After this c.

- by the funeral dir

Baltimore, Maryland 21215-0036

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

and manner stated

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a Certifier

29d. Date signed (Month, Day, Year) 29c. License number

356

2323

-200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Waseem M.D. 1126 Opal Ct. Hagerstown, Md. 21742

State Registrar

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completely filled in by

Medical

To the Hospital or within 24 hours af within 24 hours a

To the Funeral I

MAY 2 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1306 06 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHNS HOSPITAL 8. Date of Birth (Month, Day, Year) June 28, 19 Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F **Director** 1948 India <u>222-76-6420</u> Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🌠 No Director Delaware | New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

The state of Health and Mental Hygiene. In the sale of the state of the Mental Hygiene. In any or other traumatic event, the Medical Examiner must be range. 7 Fairway Road, Apartment 2-D 19711 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Asian Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Journalist Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Krishna Kumar Verma Laxmi Devi ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mridul Saran/Wife 7 Fairway Rd., Apt. 2-D, Newark, Delaware 19711 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Hockessin Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) May 7, 2007 Hockessin, Delaware Company 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician FAI HTMOM /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Er or confine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exam physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy performed? res 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director. 26. Place of Death Check onl one Other: 1 ☐ Yes 2 No 1 Minpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only manner stated. To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name

nd addre.

BALTIMORE, MD

of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Barbara Kay VanMetre /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hager 5 town Washingtor <u> Washington County Hospital</u> 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, . Age (In vrs. last birthday) **Funeral** Year) Country Months Days 1 □ M 2 <del>Q</del>F February 28,1956 Director 219-68-2298 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21740 14832 Cearfoss Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certifed Nursing Assistant Healthcare 10 h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic Ruby Betie Lee Crouse Elmer Thomas Boden ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14832 Cearfoss Pike Hagerstown, MD 21740 Mark A. VanMetre/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/18/07 Big Pool, MD Parkhead Cemetery 21 Signature of uneral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Profound Anemia **Physician** /Medical Due to (or as a consequence of): Examiner GASTROINTESTINAL BLEED MASSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner r.u.s, r.u. box 68760, fr DUDDENAL ULCER and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier machon Moder D62562 05-14-07 21140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADNAして はんぷらしか

State Registrar

Q

DHMH 17 Rev 1/2001

HOSPITAL

32 Registrar's Signature

COUNTY

31. Date filed (Month, Day, Year)

251 E ANTIETAM STREET

MAGERSTUWN MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 825 AM **Physician** 2007 Hexander /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Arunde1 Medica1 Center Annapolis Anne Anne Arundel 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**№**M 2□ F Days Hours Min. Months 73 Yrs Dec 7 1933 Maryland Director 213-26-7270 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show must be notified at Yes 2 No Annapolis Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a the Medical Examiner must b 21401 USA 2050 Gate Ct. Funeral 14. Race - American Indian 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces: 1 MYes 2 □ No If Yes, Give Year or Dates: Unk filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic even" (Specify only highest grade completed) Anne Arundel College (1-4or 5+) Elementary/Secondary (0-12) General Hospital Medical Assistant 0 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Martha Whittington Matthew Wright ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Wright(Wife) 2050 Gate Ct. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veteran 5-11-07 Crownsville, Md. Windame Reverse of &ciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 m00483 B. Reese Approximate Interval Between Onset and Death 23a. Part1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) socard /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ Month Dav Year in the past 12 months? 4☐Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be irector, page 2 s autopsy perform 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case reference examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of co D16376

State Registrar 30. Name and ad

31. Date filed

Year)

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medical Parkway, Ann apoles MD 21401

s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 1 7 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Veal **Physician** 2315 M Martha 04 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death Pacility Name (If not institution, give street and number) Examiner Wicomico ALIS BURY ENINSULA REGIONAL MEDICAL ENTER 9. Birthplace (State or Foreign Country)

MARYLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours -30-907 1 M 20 F 8 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2 No notified Ma Somerse Director FINCESS 10g. Citizen of What Country? 10e. Street and Number be "natural", or items 23a other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: BIACK Specify Maryland 21215-0036 þ 3 Widowed 4 □ Divorced 72 hours Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Shore Up permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If liem 27 is marked other than " any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Teacher Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margare 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Princess anne UNIVERSITY DR. daughter Md 21853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State -12-07 Oriole James 5 4 □ Donation 5 □ Other (Specify) Ceme tery 917 W. Isabella St 22. Name and Address of Benni Cam 21. Signature of Funeral in rvice acility Salisbury md 21901 FUNEVAL Hom a or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ast only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Megacolon Examiner Sequentially list conditions, if any, leading to inineulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ffice collitis The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, schemic Physician/Medical IF FEMALE: 23c. If yes, outcome pt pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the sahould be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has k autopsy performe 2□No 1∏ Yes or Attending Physician: after death.

Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Reuna MD DDD6399 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL ST. SHISbury Md. 21801 ANUPAMA MD VARADARAJAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 0 8 2007

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A CDonation Significant Conditions and Advanced of Facility Hodges & Edwards F. H.  21. Single of Energia Service Library  22. Name and address of Facility Hodges & Edwards F. H.  3910 Silver Hill Rd., Suitland, Md. 20746  28. Name and address of Facility Hodges & Edwards F. H.  3910 Silver Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Physician  American  29. Name and address of Facility Hodges & Edwards F. H.  3910 Silver Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approximate Interval Basishees  Cheered Hill Rd., Suitland, Md. 20746  Approxim	ore	of He of He if Item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of practory or other place)			
Physician Medical Examiner    Physician   Medical Examiner   Medical E	Ē	tment tent: tent:		4 □Donation 5 □Other (Specify) Washing				
Physician Medical Examiner  Particle Clause (Final Institute)  Sequentially feet confidence and Death Cheef an	Ba	Depar Depar Impor any In		1/10-				
Physician Medical Examiner    Part   Physician Medical   Physician Medical   Physician   P				23a. Fan 1. Enter the disease, or complications that caused the death. Do not er snock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac of	r respiratory arrest	1	Interval Between
Sequentially ist conditions.    Sequentially ist conditions   Sequentially is conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Sequentially ist conditions   Seque				disease or condition	Myocardial	Infar	CLUM	Onset and Death
Comparison of the control of the c				Due to (or as a consequence of):	had Heart	Philir	ne	
Section   Color   Co		ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):	and X	10001	2	
Section   Color   Co	dle	and I-trans	xam	that initiated events c.	asucer Bi	sease		
FEMALE:   23c. If yes, outcome of pregnancy   23c. If yes   24c. If	760,	e be ex sician e buria	aiE	Stable	tis mela	tus		
25. Was case referred to medical examiner?  1	9	tificate ig phy as the		U.				
25. Was case referred to medical examiner?  1	30X	ith cer tendin or use	an/N	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	⊒Ectopic pregnancy			•
25. Was case referred to medical examiner?  1		he dea / the at ched fo	ysici	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5			Month	Day Year
25. Was case referred to medical examiner?  1		s that I	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
25. Was case referred to medical examiner?  1	E C	en sig				1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
25. Was case referred to medical examiner?  1	ပ္ပ	law re as be	plet				24b. Were aut	opsy findings available
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and decess of pers II who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)	E		Co			performe	d? death?	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and decess of pers II who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)	<u>₹</u>	sician certifi rector	0	examiner?	Other			
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and decess of pers II who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)	ō	g Physer this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of	TIL 3 DOA 4 RUISING HO			ıfy)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and decess of pers II who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)	<u>o</u>	ath. r: Afte	atio	12 Hatelan 5 I briding				
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and decess of pers II who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)	DIVIS	l or Atte aftar de Directo i in by th	ertific	determined 200. Flace of injury - At flome, farm, si	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)		24 hours 25 hours Funeral		Check only 2   Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a livestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
30. Name and address of pers II who completed cause of death (Item 23a) (Type, Print)		To th within To the	Me		29c. License number	29d	. Date signed (Month	Day, Year)
				> Chaperenn	04360	6	5/14/0	7
		21		30. Name and address of pers 11 who completed cause of death (Item 23a) (Type	Print)		1	
Registrar MAY 2 2 2007				Obafemi Opesanmi, M.D., 7503 S	urratts, Rd., C	linton,	Md. 2073	35
			_	MAY 2 2 2007	who are			

DHMH 17 Rev 1/2001

**Physician** /Medicai Examiner Examiner The law requires that the death certificate be executed and

**Physician** 

/Medical

Examiner

10a. State

Md.

12

**Funeral** 

Director

28a-f show

ŏ be

items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland 21215-0036

notified

Director

Funeral

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Completed

Be

with the Maryland

buriai-trai physician as attending ō the ģ certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 2 Certification: Medical

Division or Vital Records, P.O. Box 68760

Physician/Medical 23b. Was decedent pregnant 9 Unknown Completed

	. *************************************	a to inculcal				20. Flace of D	eath (Check only one)		
	examiner? 1 ☐ Yes 2 ☐ N	lo	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 🔲 1	DOA Other: 4 Nursing	Home 5 Residence	6 Dether (Specify	ASSISTED
27.	Manner of Death 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	LIVIN
	3 ☐ Suicide 4 ☐ Hornicide	6 Could not be determined	28e. Place of injury - At building, etc. (Spe	home, farm, stree cify)	t, fact	ory, office	28f. Location (Street: City or Town, Sta		l Route Number,

29a. Certifier

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHANDION, MD 3333 N. CALVERT & 321 BALTIMONE, MD 31. Date filed (Month, Day, Year) MAY 2 3

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5, perFH, 9868, 6/14/07 IT

Continued of Department of Health and Mental Hygiene

1- Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 May Lorene H. Austin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery <u>Suburban Hospital</u> 5. Social Security Number Birthplace (State or Foreign Country) Year If Under 24 Hrs Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Months Days Min. 1 □ M 2 TF Yrs. 79 Aug. 25, 1927 Minnesota Director 473-26-<del>2252</del> Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 20817 United States 9422 Bulls Run Parkway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🐼 No Specify Specify. <u>ک</u> White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Kappahn Joseph Julig ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9422 Bulls Run Parkway, Bethesda, Maryland 20817 Marie R. Austin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition June 12, W Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2007 Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee M00198 au Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Fuchysema

Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy
performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 🕅 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after 4 ☐ Homicide 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number May 21, 2007 D0063195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven David Wilks, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 3 2007

0025Am

to/10/50

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 420 **Physician** AM Mai-2007 le DUKAN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 17F 213-56-6217 53 Director 30 1953 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at MD Howard Dayton 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r USA 21036 4851 Ten Oaks Road Pages 1 and 2 should be filed within 72 hours after death vent of Heath and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2√ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 item 27 is marked other other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Raymond Francis Hill Betty Miles ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4851 Ten Oaks Road, Dayton, MD 21036 Mr. Warren Bell (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Linthicum Chapel Cem | 5-25-07 |Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 21. Signature of Funeral Service License Paige Haight & evident Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ademocaccinems Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ D**O**A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

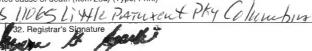
10

within 24

State Registrar

31. Date filed (Month, Day, Year) MAY 2 3 2007

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

D38509

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	te of Maryland / [	Certifica:				eg. No. 2	0 0 7	1665
	(F	Hegistrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dear	th		3. Time of Death
Physicia		THOMAS	BUGHER				Month MAY	Day	Year 2007	0845 4 M
/Medic Examin		4a. Facility Name (If not institution, give street as	nd number)	4b. City	, Town, or Lo	cation of Death	· ·	4c. Cou	nty of Death	
	34	NOCTHWEST HOSE	TAL			LLS TON H			LTIMO	
Funeral Director		5. Social Security Number 6. Sex 15x 20	7. Age (In yrs. last bir	Yrs. If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 3	. Year)	Cor	nplace (State or Foreignitry)
2		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limit
a-f shov	ctor	MD Carroll		ersburg						1   Yes 2   1
23a or 28	Funeral Director	10e. Street and Number 7070 MacBeth Way			p Code 784			og. Citizen USA		
permit. Plages 1 and 2 should be filed within 7 z hours after death with the maryland. Department of Health and Mential Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at once.	y Funer	1 Never Married 2 Married	s Decedent Ever in U.S. ned Forces? Yes 2 No WWII	13. Was Dece If Yes, sp 1 ☐ Yes	ecify Cuban,	anic Origin? (Spe Mexican, Puerto <i>Specify:</i>	ecify Yes or No- Rican, etc.)	E	Race - Ame Black, White Boile: whi	
natural", dical Ex	eted by	3 □ Widowed 4 □ Divorced Year  15. Decedent's Education (Specify only highest grade comp.)		Decedent's Us (Give kind of w	ork done dun	on ing most of worki	ing	16b. Kind o		
giene. rr than " the Med	omple		lege (1-4or 5+)	ontract		rementer		cont	ract	
ental Hy ked othe c event,	To Be Completed	17. Father's Name ( <i>First, Middle, Last</i> ) William Bugher				3. Mother's Name Elsie Bu			name)	
nd 2 snou Ith and M 27 Is marl traumati	-	19a. Informant's Name/Relationship (Type. Prii Sara Lloyd (granddaug	,	o. Mailing Addres	ss (Street and eth Wa	Number or Rura y, Elder	sburg,	r, City or To MD 21	wn, State, 2 784	?ip Code)
ages 1 ar int of Hea t: If item ? y or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State cemete	of Disposition (Na ery, crematory or unty Cr	other place)	1	Oate -07	20c. Location	-	Town, State
Departme Mportani any injury		21. Signature of Funeral Service Licensee  Physical Licensee		22. Name a	and Address	of FacilityHaig 5 Sykesy	ght Fune	ral H	ome &	
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus								Approximate Interval Between
hysician be executed // Medical stansit street private transit street presearch street private transit street private transit street priv	al Examiner	if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events c	Oue to (or as a consequence	roij.	Risess					
e attending	Physician/Medical	in the past 12 months?	es, outcome pf pregnancy ]Live birth 2 □ Fetal deat ]Pregnant at time of death ]Unknown	h 3⊟Ectopic 5⊟ Other (				23d.	Date of de	livery Day Year
requires tnat the een signed by th nould be detache	b	Part II. Other significant conditions contribution	ng to death but not resulting	in the underlying	cause given	in Part I.				o the cause of death?
e law has b je 2 sl	Completed						24a. Was autor perfo 1 Yes	rmed?	4b. Were a prior to death?	utopsy findings availa completion of cause
certificate ector, pag	Be (	25. Was case referred to medical examiner?	t.		Other:	26. Place of Deat				
ng Pnys fter this ineral dir	on: To	1	1 Inpatient 2 EH/C	. Time of Injury	28c. Injury a Work?	at Nursing H	ome 5 ☐ Resident Resident Period Resident Period Resident Period Resident			ecify)
To the Hospital or Attending within 24 hours alter death.  To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investigation	e. Place of injury - At home, the building, etc. (Specify)	M farm, street, fact		es 2 □ No	28f. Location (S City or Tox		lumber or R	ural Route Number,
Hospital 24 hours a Funeral I	Medical Ce	(Check only 2 Medical Examiner: C	: To the best of my knowledon the basis of examination and manner stated.	ge, death occurr and/or investigat	ed at the time on, in my opi	, date and place nion, death occu	, and due to the rred at the time,	cause(s) an date and pl	d manner a ace, and du	s stated. e to the cause(s)
To the Howithin 24 To the Force complete	Med	29b. Signature and title of certifier	in manner stated.	2	29c. License i	number		29d. Date s	igned (Mon	th, Day, Year)
		Defits some	~		Do	059736		ma	7 22	2007
5		30. Name and address of pron who complete	PATPICK, ma	NURT	HWFJ7	HOSPITAL	540	OLB	COUR	T ROAD
St Regist	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	book						

07-03746 Cherish J. Brown

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2007 16656

		For State		Certii	icate oi	Dealii			I O. Data	Reg. of Death	No.	3.7	ime of Death
Physicia		. Decedent's Name (First, Midd							Z. Date Mont	16, 200	ay Year		2100 hrs
Examir		Cherish J.	Brown							16, 200	) /		
		a. Facility Name (if not instituti	on, give street and numb	ег)		4b. City, Tow		ocation of De	eath		4c. County o	Death	
		Sinai Hospital				Baltimo	re						
		. Social Security Number	6. Sex 7.	Age (In yrs. last	birthday)	If Under 1	Year		Hrs. 8. Da	te of Birth	(MM/DD/YYYY)	9. Birthpla	ace (State or
Funeral	٦	218-75-2433	0.00				Days	Hours	Min. 6/	9/20	06	Foreign Country	MD [
Director	ı	210-73-2433	1 M 2 X F		Yrs	3. 11	_/_					<del></del>	
	Ī	Jsual Residence of Decedent		Ido- Oite T	own or Loca	tion						100	d. Inside City Limits
amy	Γ.	10a. State 10b. County		Tuc. City, 10								1	XXYes 2 No
ie de	-1	MD N	/A	1	Ball	imore			* 1	1170		10	
Aaryland 28a-f show any 1 at once.	용는	10e. Street and Number				10f. Zip Co		4046		100	g. Citizen of Wh	USA	•
e Ma or 28	Director	2401 Aller	ndale Road				2	1216		- 1		USA	
th the Maryland 23a or 28a-f sho notified at once.			12 Was Dece	dent Ever in U.S	. 13. W	as Decedent	of Hisp	anic Origin?	( Specify Y	es or No-			Indian, Black,
h wir	Funeral	11. Marital Status 1 X Never Married 2	Married Armed Ford		If '	Yes, specify (	Cuban,	Mexican, Pu	uerto Rican,	etc.)	VVnite	e, etc.	ack
deat or it	.≒\		1 Yes	2 🗶 No	1	Yes 2 X	ζ No	specify:			Specify:	DI	ack
after al",	À		Divorced If Yes, Give Year or Dates:	lated)	16a Decede	ent's Usual O	-		d of work do	ne	16b. Kind of Bu	ısiness/Indu	ustry
hours af natural		15. Decedent's Education (Sp			during	most of worki	ng life.	DO NOT use	e retired)				
72 h 12 h 12 h	ompleted	Elementary/Secondary (0-12	College (1-4	4 or 5+)		r	ı/a					n/a	
thin refiner	8	0					- 12	Q Mathor's h	Name /Firet	Middle M	laiden Surname	e)	
Sd w sd w lygie other he h	Ŝ	17. Father's Name (First, Midd	lle, Last)					Tiffa				,	
215 e fil tal H ked	မ္က	Anthony Sim							_			m State 7	in Code)
21215-0036 Juld be filed within 73 Mental Hygiene. market other than	흔	19a. informant's Name/Relation	nship (Type, Print)	1.	19b. Maili	ng Address	Stree) ろこっ	t and Numbe	er or Rural F	toute Num	ber, City or Tove	216	ip occupy
MD 21215-0036 d.2 should after death with the Maryland that and Mental Hygiene at the Maryland thith and Mental Hygiene "natural", or items 23a or 28a-f she aumatic event, the Medical Examiner must be notified at once		Tiffany M.	Brown / Mot								20c. Location		wn State
and 2 and 2 ealth tem 2 traus		20a. Method of Disposition		20b. P	lace of Disp	osition (Name	e of cer	netery,	Date				
of H	ш	20a. Method of Disposition  1 X Burial 2 Cremat	tion 3 Removal fro	m State HOT	Ty"HI	LT Mem.	. Gá	ardens	5/2	3/200	/ MIGG	re win	er, mo
Battimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 permit of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		4 Donation 5 Other	Specify:									_	
Balti permit. Departn Import	l W	2. Signature of Funeral Service	Victor P.	Doda, J	r Ći	naries naries	Ľ.	Steve	ns Fu	neral	Home, more M	Inc	an l
ii ii g c g		JILOTS			11:	501 E.	FOI	rt Ave	nue,	iratory arr	est shock or h	eart	Approximate Interval
ysician		23a. Part I. Enter the discusse failure. List only one cau	or complications that ca	used the death.	Do not ente	r the mode of	r ayıng,	Such as care	ulac oi Tesp	ii atory arr	oot, one on, or		Between Onset and Death
Aedical			C	nexplaine	d death	in infa	ancy						Dealit
Examiner		Immediate Cause (Final disea or condition resulting in death	Due to (or as a	consequence of	j):							1	
			b.										
	ē	Sequentially list conditions, if any, leading to immediate		consequence of	f):							Ì	
	n/Medical Examiner	cause. Enter Underlying Cau (Disease or injury that initiate											
	×a	events resulting in death) La		consequence o	T):								
3760, ficate be executed g physician and s the burial - transis	1 111		d										
exectian a	<u>:</u>	X UNPENDED	#MENDED	,28a-f, p	erME.g8	69. 7/2	4/07	TT					
8760, ificate be ng physic	Je l	IF FEMALE:	23c. If yes,	outcome of preg	nancy							of delivery Da	av Year
876 iifica ng ph	5	23b. Was decedent pregnant			_	Fetal death	3	Ectopic	pregnancy		Month	De	ay 100
C 6	<u>응</u>	past 12 months?		nant at time of de	eath 5	Other (Spec	cify)				ł		
Box 68 Le death certi r the attending	Physicia	1 Yes 2 V No 9		_		_				ODo Did	tobacco use co	ntribute to t	he cause of death?
Records, P.O. Box 68 The law requires that the death certi cate has been signed by the attendin more 2 should be detached for use as	돈		nditions contributing t	o death but not r	esulting in t	he underlying	cause	given in Par	rt I.				ably 4 Unknown
P.C S that s that	2								"	1Y			
S, quire an signal ld b	E									24a. Was	s an 24	<ul> <li>D. Were aut</li> <li>D. Drior to C</li> </ul>	topsy findings available ompletion of cause of
w rec	=									perf	ormed?	death?	·
ecc ne lar te ha	Completed									1 Yes	2 No	1 🗸 Ye	s 2 No
I: II	၂ပ		edical				26.Pla	ce of Death (	(Check only	one)			
iciar iciar s cer	B	examiner?	Hospital:	Inpatient 2	ER/Outpa	tient 3	AOC	Other <sub>4</sub>	Nursing H		Residence		
Division of Vital Records, P.O. Box 68760, tal order death certificate be executed its after death.  Is after death.  In Director: After this certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the deathed for use as the burial - trainsit.	2	27 Manner of Death	28a Date	e of Injury	28b. Time		28c. In	jury at Work	? 286	d. Describ	e how injury oc	curred	
o ling	<u> </u>	1 Natural 5		th, Day, Year)	١,		1	Yes 2 X	No u	nk			
ior:	Certification:	2 Accident	Pending Fnd 5	0/16/2007 lice of Injury - At	unk bome farm	street factor				f. Location	(Street and Nu	ımber or Ru	ral Route Number, City
VIS or Al fter of Jirec	i i	3 Suicide 6 X	Could not be			Street, lactor	,, OIIIO	3		or Town	State)		ltimore, MD
Divi pital or ours afte	1	4 Homicide	determined (Specify										
Division of Vital Division of Vital Vother Hospital or Attending Physician: within 24 hours after death.			ng Physician: To the be	est of my knowle	dge, death o	occurred at th	e time,	date and pla	ace, and du	e to the ca	iuse(s) and mat te and place a	nd due to th	ne cause(s)
the I	Modical	one) 2 Medica	ng Physician: To the be I Examiner:On the basis and manner	s of examination	and/or inves	stigation, in fr	ny opini	on, death oc		o unio, ua			
5 Mil 5		29b. Signature and title of c		J. 100.		29	9c. Lice	nse number			1		nth, Day, Year)
	-	1 1	01.0	2 22	10	1	0.0	C.M <b>.</b> E.			May 17	, 2007	
~		Jacol	15491	1100	ev .	L							
7 1		30. Name and address of p		use of death (Ite	em 23a)	111 Penn	Stron	t Raltimo	ore. MD 1	21201			
V		Tasha Greenberg		Medical Exa		i i i reiiii	Suet	,, Damini					
	Stat	e 31. Date filed (Month, Day,	Year) 32.	Figistrar's Signa	ature	boarte	,						
Reg	istra		2227	Jours Jours	J.J.	100							

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			For State Registrar	otato or mi		ertificate of		vioritatiriy	Reg. No	07 1	6657
i	Physici		1. Decedent's Name (First, Middle, Last)  Ronald F. Bar	+010				2. Date of De Month	Day	Year	Time of Death
-	/Medio		4a. Facility Name (If not institution, give st			4b. City, Town,	, or Location of Death		4c. County		
Ĭ	CXAIIIII	iei	- A 1	OSPITAL		BALTIM	IORE				
	Funeral		Social Security Number 6. Sex	7. Ag	e (In yrs. last birthda		ar If Under 24 Hrs.	8. Date of Bir (Month, Da	rth av. Year)	9. Birthplace ( Country)	(State or Foreign
ш	Director		216-32-9511	M 2□F	69 Yrs.	World Day	3 FIGURE			Maryla	nd
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. In	side City Limits
	faryla fsho ed at	ō	Manual and Daltima			1 ئىسى سى شەر	1			1	□Yes 2X No
	the 28a-	Director	Maryland Baltimo  10e. Street and Number	re		Catonsvil 10f. Zip Code			10g. Citizen of V	Vhat Country?	
	3a or		715 Maiden Choice	Lane Ap	t 512CC	21	1228		USA		
	death	Funeral	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Decedent of	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No	0- 14. Raci	e - American Inc k, White, etc.	dian,
39	urs after al", or ite xamine	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ N		o modification	Specify	T.T	
15-0036	be filed within 72 hours after death with the Maryland Hygiene.  I'd Hygiene.  I'd other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Gir	edent's Usual Occ ve kind of work don DO NOT use reti	ne during most of wor	king	16b. Kind of Bu	usiness/Industry	
Maryland 2121	withi	E O	Elementary/Secondary (0-12)	College (1-4or 5	Sale	s and En	trepreneui	c	Retai	L	
		S S	17. Father's Name (First, Middle, Last)	-			18. Mother's Nan	ne (First, Middle	e, Maiden Surnam	ne)	
/lar	ould be Mental arked o	TO E	Dewey Price				Mol	lly Phil	llips		
an	2 sho and I Is ma		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Ma	iling Address (Stre	et and Number or Ru	ıral Route Numl	ber, City or Town,	State, Zip Code	<del>)</del>
3, ≤	and lealth m 27 her tr		Marlyn Knott - Si	ster			own Road;	Baltimo Date			24-4-
0	iges 1 nt of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		1	position (Name of rematory or other p	1		20c. Location -		
altimore,	it. Pa rtmer rtant: njury		4 □ Donation 5 ☑ Other (Specify) ☐ 21. Signature of Funeral Service License		t Loudon	Park	5-2 dress of Facility St	23-2007 erling-	Baltimo	ore, Mar	yland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evone.		21. Signature of Funeral Service Licenser	Valle		Funeral I	Home of Ca ondson Ave	tonsvil	le, Inc	o MD	11228
			23a. Part1. Enter the disease, or complic	ations that caused	the death. Do not e					App	roximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final	SEPTIC	5					Ons	rval Between et and Death
	/Medical		disease or condition resulting in death)		a consequence of):						· Days
	Examiner		Sequentially list conditions b.	Pancyto						Two	, Months
V	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t for as	a consequence of):	0					Months Months
4	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	Cancer				Two	Months
60,	be exician burial	al E		Due to (or as	a consequence =).						
687	ficate phys s the		d.								
Box	eath certificate be executed attending physician and for use as the burial-transit	ğ	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome					23d. Dat	te of delivery	
	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊔Live birth 4⊟Pregnant a 9⊟Unknown		B⊟Ectopic pregnat □ Other (specify)			Мо	onth Day	Year
, P.O	res that the de signed by the a be detached t		Part II. Other significant conditions confi	ributing to death b	ut not resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use cont	ribute to the car	use of death?
Vital Records,	w requires been sign should be	ed by	DIABETES MELLITUS,	CORONAR	Y ARTERY	DISEASE	STATUS	1 🗆	Yes 2□ No	3 Probably	4 □Unknown
900	has bee	Completed	POST MYOCARPINE	INFARCTI	ON, CHRONI	· RENAL	INSUFFICIEN	ey 24a. Was		Were autopsy fi prior to complet	indings available
ř		E O			•			perf	formed?	death? 1 ∐ Yes 2 □	
/ita	<b>hysician:</b> The Is his certificate ha: I director, page 2	Be (	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only	one)		
or.	Physical this call dire	၉	TI TES ZIM NO	ospital: 1 Impatie		elit 3 DOA		1	sidence 6 Oth		
UC C	Jing F	io	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		/ W	njury at Vork? □ Yes 2 □ No	280. Describe	how injury occur	rea	
Division or	Attending Ph or death. ector: After th by the funeral	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inj	ury - At home, farm,			28f. Location	(Street and Numb	er or Rural Rou	ute Number.
<u>&gt;</u>	after Direction of the control of th	Certification:	4 ☐ Homicide determined		c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, State)		
	To the Hospital or Attending PhysIclan: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; p		29a. Certifier 1 Certifying Phys								
	he Hc in 24 l he Fu pletely	Medical	(Check only 2 ☐ Medical Examin one)	er: On the basis o and manner st				urred at the time	e, date and place,	and due to the	cause(s)
	with To t	Σ	29b. Signature and title of certifier	/	7	29c. Lice	ense number		29d. Date signe	d (Month, Day,	Year)
			1-	8			P20654		MAY 6	10, 200	7
	الام		30. Name and address of person who cor	npleted cause of c	eath (Item 23a) (Typ	e, Print)					

12+1

BARTELS, RONALD

State Registrar

ZESHAN A RASPUT, 31. Date filed (Month, Day, Yéar)

900 South Caron
32. Registrar's Signature

AVENUE

BALTIMORE, MARYLAND

			For State Registrar	State o	f Maryla		artment of H		nd Mer	ntal Hy	giene Reg. No	200	a constraint	16658
	Physicia /Medic	al	1. Decedent's Name (First, Middle Rose Betty F	Selton	mhori		4b. City, Town, or	r Location of F		Date of De Month May	16, Da	y Ye. 2007 . County of D	ar	3. Time of Death 8:50 A.
	Examin Funeral		4a. Facility Name (If not institution,  Catonsville Co  5. Social Security Number	ommons-Ge:	nesis	rs. last birthday)	Catons  If Under 1 Year  Months Days	ville _ If Under 24	Hrs.   8.	Date of Bir (Month, Da	rth	Balti	more	e (State or Foreign
	Director		220-22-1239  Usual Residence of Decedent  10a. State 10b. County	1 □ M 2 🛣 F	79	Yrs.  City, Town or Lo		Tiodio	Ja	an. 2	<b>0,</b> 1		aryl	
	h the Maryl r 28a-f sho notified at	Director	Maryland Baltin  10e. Street and Number	nore		Catons	ville   10f. Zip Code				10g. Cit	izen of What	Country'	1 □ Yes 2 <b>∑</b> No
	h wit	a D	609 Woodsdale F	Road			212	28				USA		
2-003p	be filed within 72 hours after death with the Maryland Hygiene.  Independent an "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 🗓 Marrie 3 □ Widowed 4 □ Divorced	12. Was Dec Armed Fe ed 1 ☐ Yes If Yes, Gi Year or D	orces? 2 ⊡kNo ve	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin an, Mexican, F Specify:	n? (Specify Puerto Ric	Yes or No an, etc.)	0-	14. Race - A Black, W Specify:	merican /hite, etc. Whi	•
1212-0	filed within 72 h Hygiene. Ither than "natu int, the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of d)	f working		16b. K	ind of Busine		try
iana z	2 should be filed vand Mental Hygie Is marked other is marked other is	To Be Co	17. Father's Name (First, Middle, I Charles E. Mil	•		_   Sal	es Associ	18. Mother's	Name (F		e, Maiden	Reta Surname)	11	
, mary	permit. Pages 1 and 2 should by Department of Health and Mentis Important: If item 27 is marked any Injury or other traumatic ev once.		19a. Informant's Name/Relationsh Donald F. Bell		sband		ng Address (Street				-			,
painmore	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	oudon P	osition (Name of matory or other place ark Cemet	ery 5		2007	Bal		, Ma	ryland
חמו	permit. Departi Importi any inj		21. Signature of John ral Service)	icolsee	Mo	/296 1	2. Name and Addre uneral Ho 630 Edmon	ss of Facility me of dson A	Ster Cator venue	ling nsvil e; Ca	Ashte le, tons	on Sch Inc. ville,	wab _MD	Witzke 21228
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Find disease or condition resulting in death)	complications that only one cause on o	each line.		ter the mode of dyir	0			arrest,		Ap In Or	pproximate terval Between nset and Death
,007	Medical Examiner  hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a cons	sequence of):								•
.O. box ox	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown		birth 2 ☐ F nant at time (	etal death 3[	□Ectopic pregnancy □ Other (specify)	1				23d. Date of Month	delivery Da	ay Year
cords, r	equires that en signed to ould be deta	ρχ	Part II. Other significant condition	ns contributing to d	eath but not	resulting in the u	inderlying cause giv	en in Part I.				use contribut		cause of death?
ב ב		Completed					-			24a. Was auto perf 1□ Yes		prior deat	to compl h?	/ findings available letion of cause of ☐ No
ומ	cian sertifi sctor	Be	25. Was case referred to medical examiner?	Linesibele			l ou	26. Place of	Death (C	heck only	one)			
SIOII OI	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	tion: To	1 Yes 2 100  27. Manner of Death 1 1 Natural 5 Pending 2 Accident investig	28a. Date (Mor		2 ER/Outpaties 28b. Time of Injury	of 28c. Injur Wor	4 Nursi	28d			6 ☐Other (5 ry occurred	Specify)	
	tal or Atter s after deat al Director ed in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	e of injury - A ling, etc. <i>(Spi</i>	t home, farm, streecify)	reet, factory, office	100	28f.	Location ( City or To	(Street ar own, State	nd Number o	r Rural R	oute Number,
	the Hospil: hin 24 hour the Funer: npletely fills	edical	(Check only 2 Medical I	Physician: To the Examiner: On the sand man	e best of my basis of examiner stated	knowledge, deat nination and/or in	th occurred at the tin nvestigation, in my o	me, date and popinion, death	place, and occurred	due to the at the time	e cause(s	and manne od place, and	r as state due to th	ed. e cause(s)
)		Σ	29b. Signature and title of certifier	٠٠٠٠.	<i>[</i> ]	745	Print)	694°	2		29d. Da	Resigned (M ス 18	onth, Day	o 0 7
	\ D Sta	to	30. Name and address of person of the state	who completed cau	se of death (	gnature	Print)	Q D.	BAI	ーナノル	nore	( My	2	1228
	Registr		MAY 2	3 2007	The Store	A. A.	COMME							

			1 - State of Mary Registrar		tificate of D		, ,	eg. No. 0 0 0 7	ICCEO
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th CUU	3. Time of Death
	Physicia /Medic		Marie V. Brotman				Month May 16	Day Year 2007	11:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Death	
			Ridgeway Manor Nursing Ho		Catonsv			Balti	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (III 1 M 2 1 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	In yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day) Feb. 14,		place (State or Foreign ntry)
	•		Usual Residence of Decedent				100.17,		
	arylar show d at	_	10a. State   10b. County   10   Maryland Baltimore   10	Oc. City, Town or Loc Baltimore				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma 28a-f	Director		Dartimore	_				
	with tags or 2	Di	10e. Street and Number 5434 Whitlock Road		10f. Zip Code	229	1	0g. Citizen of What Cour	ntry?
	ms 2: mus	Funeral	11. Marital Status 12. Was Decedent Eve	er in U.S. 13. W	Vas Decedent of His f Yes, specify Cubar	-	ecify Yes or No-	14. Race - Americ	
9500	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 S No If Yes, Give Year or Dates:		rYes, specify Cubar □Yes 2☑ No	Specify:	Hican, etc.)	Black, White, Specify: Whi	
2	72 hc "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede (Give k	lent's Usual Occupa kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of Business/Ind	dustry
Z	within ene. than '	ig m	Elementary/Secondary (0-12) College (1-4or 5+)		onemaker			Own Home	
N 0	filed v Hygie other i		17. Father's Name (First, Middle, Last)	n n		18. Mother's Name	e (First, Middle, I		:
Z O	should be nd Mental marked o	To Be	Frank Hefner				DeUnger	,	
	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State, Zip	
Ξ,	and 2 lealth a m 27 is		Lynn Markus Daughter	1		urt; Bal	timore,	Maryland 21	227
ore	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other place	) :		20c. Location - City or To	
Daltimol	t. Pac rtmen rtant: njury		4 □ Donation 5 □ Other (Specify)	Loudon Pa				Baltimore, N	
ם מ	permit. Page Department Important: If any injury or once.		21. Signature of Juneral Service Licensee	116	530 Edmond	lson Aver	nue: Cat	shton Schwal e,Inc. onsville, M	D 21228
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a	hypto	me of	study	w hn	a disin	Onset and Death
	/Medical Examiner		Due to (or as a co	onsequence of):	1	(*)		7	/
				. 1/1		1 -	0		/ /
		er	Sequentially list conditions, if any, leading to immediate b.	onsequence of).	uno sci	intro	dra	y doing	10 grs
	cuted of ansit	ıminer	cause. Enter Underlying Cause (Disease or injury	Onsequence of).	ino sci	entic	dro	em	10 grs
Ď,	e executed an and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a condition of the condition of the cause)  c.  Due to (or as a condition of the cause)		ino su	entic	dro	in	10 grs
0,007	ate be executed hysician and the burial-transit	fical Examiner	that initiated events c		ino sci	entic	di	in	10 grs
_	ertificate be executed ding physician and se as the burial-transit	edical	resulting in death) Last  C. Due to (or as a co	onsequence of):	ino su	entic	ds		10 grs
DOX 00/00,	eath certificate be executed attending physician and for use as the burial-transit	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	onsequence of):  pregnancy  Fetal death 3	Ectopic pregnancy	entic	dra	23d. Date of delive Month	ery Day Year
_	the death certificate be executed y the attending physician and iched for use as the burial-transit	edical	resulting in death) Last  C. Due to (or as a condition of the condition of	onsequence of):  pregnancy  Fetal death 3		entic	dro	23d. Date of delive	
P.O. DOX	s that the death certificate be executed ned by the attending physician and e detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	pregnancy Fetal death 5	Ectopic pregnancy			23d. Date of delive	Day Year
P.O. DOX	equires that the death certificate be executed as signed by the attending physician and ould be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown	pregnancy Fetal death 5	Ectopic pregnancy			23d. Date of delive Month	Day Year
necords, P.O. box	aw requires that the death certil as been signed by the attending 2 should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown	pregnancy Fetal death 5	Ectopic pregnancy		23e. Did tol 1 Ye	23d. Date of deliver Month  bacco use contribute to these 2 No 3 Proben Professor Prof	Day Year  ne cause of death?  pably 4 x nknown  psy findings available mpletion of cause of
necords, P.O. box	aw requires that the death certil as been signed by the attending 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but no	pregnancy Fetal death 5	Ectopic pregnancy Other (specify) derlying cause given		23e. Did tol 1	23d. Date of deliver Month  bacco use contribute to these 2 \( \sum \) No 3 \( \sum \) Prob  24b. Were auto prior to coideath? 24 \( \sum \) No 1 \( \sum \) Yes	Day Year  ne cause of death?  pably 4 nknown
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r vital necords, P.O. DOX	aw requires that the death certil as been signed by the attending 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1	pregnancy   Fetal death   3   ne of death   5   not resulting in the uncertainty   2   ER/Outpatient   28b. Time of linjury	DEctopic pregnancy Other (specify)  Inderlying cause given  The specific of th	26. Place of Death	23e. Did tol  1  Yes  24a. Was a autops perfori 1  Yes  1 (Check only on me 5  Reside 28d. Describe ho	23d. Date of deliver Month  bacco use contribute to the ses 2 \( \text{No} \) 3 \( \text{Prob} \) Prob  24b. Were auto prior to condeath? 25 \( \text{No} \) 1 \( \text{Yes} \)  ence 6 \( \text{Other (Specify own injury occurred} \)	Day Year  ne cause of death?  pably 4 x nknown  psy findings available mpletion of cause of  2 \[ \sum No \]
r vital necords, P.O. DOX	aw requires that the death certil as been signed by the attending 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1	pregnancy   Fetal death   3     ne of death   5     not resulting in the uncertainty     2   ER/Outpatient     28b. Time of     injury     At home, farm, stre	DEctopic pregnancy Other (specify)  Inderlying cause given  The specific of th	26. Place of Death	23e. Did tol  1  Yes  24a. Was a autops perfori 1  Yes  1 (Check only on me 5  Reside 28d. Describe ho	23d. Date of deliver Month  bacco use contribute to the set 2   No 3   Probestor to condeath?  24b. Were auto prior to condeath?  1   Yes  e)  ence 6   Other (Specification of the set)  ow injury occurred	Day Year  ne cause of death?  pably 4 x nknown  psy findings available mpletion of cause of  2 \[ \sum No \]
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r vital necords, P.O. DOX	aw requires that the death certil as been signed by the attending 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 morths?   1   1   Live birth   2   4   Pregnant at im 9   Unknown   9   Unknown   1   1   Live birth   2   4   Pregnant at im 9   Unknown   25. Was case referred to medical examiner?   1   Yes   2   No   27. Manne of Death   1   Natural   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   28a. Date of Injury (Month, Day Yes)   29a. Certifier (Check only one)   21   Medical Examiner: On the basis of exand manner stated   29b. Signature and title of certifier   30. Name and address of person who completed cause of death	pregnancy   Fetal death   5   ne of death   5   not resulting in the unit resulting in t	Deet, factory, office	26. Place of Death T. 4 Nursing Ho at es 2 No	23e. Did tol  1	23d. Date of deliver Month  bacco use contribute to the set of the	ne cause of death?  ne cause of death?  pably 4 nknown  psy findings available mpletion of cause of  2 No  No  No  No  No  No  No  No  No  No
I vilai necolds, r.O. box	To the Hospital or Attending Physician: The law requires that the death certifully a within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use an	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 morths?   1   1   Live birth   2   4   Pregnant at implement   9   Unknown   9   Unknown   9   Unknown   1   Matural   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   28a. Date of Injury (Month, Day Yellow)   28a. Place of injury (Month, Day Yellow)   28a. Place of injury (Month, Day Yellow)   28a. Certifier (Check only one)   28a. Date of Injury (Month, Day Yellow)   28a. Place of Injury (Check only one)   28a. Place of Injury (Month, Day Yellow)   28a. P	pregnancy   Fetal death   5   ne of death   5   not resulting in the unit resulting in t	Deet, factory, office	26. Place of Death T. 4 Nursing Ho at es 2 No	23e. Did tol  1	23d. Date of deliver Month  bacco use contribute to the set of the	ne cause of death?  ne cause of death?  pably 4 nknown  psy findings available mpletion of cause of  2 No  No  No  No  No  No  No  No  No  No

DHMH 17 Rev 1/2001

**ORIGINAL** 

			artment of Health and Mertificate of Death	Reg.	for U U I	16660
Physici /Medio		1. Decedent's Name (First, Middle, Last)  Elaine Brewingt	on	2. Date of Death Month May 13	8 <sup>ay</sup> 2007	3. Time of Death 2:30P M
Examin		4a. Fecility Name (If not institution, give street and number) 9131 September Lane	4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgome	ery
Funeral Director		5. Social Security Number 6. Sex 1 M 25 F 7. Age (In yrs. last birthday 87 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth December	1919 9. Birth 27 Mary	pplace (State or Foreign Tand
Maryland 9-f ehow ified at	tor	10a. State				10d. Inside City Limits 1 K Yes 2 □ No
with the	i Direc	10e. Street and Number 9131 Septmeber Lane	10f. Zip Code 20901	10g.	Citizen of What Cou USA	untry?
be filed within 72 hours after death with the Maryland tall Hygiene.  to other than "natural", or items 23a or 28e-f show event, the Marical Examiner must be mailfied a	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Note of Microscology  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B	
nd 2 should be filed within 72 hours aff lift and Martal Hygiens 27 is marked other than "natural", or rearmatic event, the Martical Exami	Completed by	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) STESS	ing	Kind of Business/li	ndustry
should be filed nd Mental Hygi markad other imatic event, it	To Be C	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name Marie	Egglesto		
nd 2 shou alth and N 27 is mar		19a. Informant's Name/Relationship (Type, Print)  Marian Brewington/ Daughter  9131	ing Address <i>(Street and Number or Run</i> September Lane, S	al Route Number, Ci ilver Spr	ty or Town, State, Zi ing, MD	ip Code) 20901
permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any injury or other traumatic once.		123 Bunal 2 □ Cremation 3 □ Hemoval from State  14 □ Dopation 5 □ Other (Specify)  Mount Pe	ace Cemetery 05/24	/2007 Pl	Location - City or T	ia, PA
permit. Depart Import any inj		4/ 1	22. Name and Address of Facility Jo 716 Kennedy St. NW			neral Home 20011
Pnysician /Medical		23a. Part 1. Date the disease of complications that caused the death. Do not e shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
be executed icien and purial-transit	dicai Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, learning to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
the death certificate by the attending phys ached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
that ad to deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?
The law ate has b	Completed			24a. Was an autopsy performed 1 ☐ Yes 2€	? prior to co	topsy findings available ompletion of cause of 2 No
2 2	ition; To Be	25. Was case referred to medical examiner?  1	ent 3 DOA Other: 4 Nursing Ho	h (Check only one) me 5 A Residence 28d. Describe how in		ify)
or Attending after death. I Diractor: Afte d in by the fune	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S		ral Route Number,
To the Hospital or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai C	29a. Certifier  (Check only one)  1  Certifying Physician: To the best of my knowledge, de: 2 Medical Examiner: On the basis of examination and/or and manner stated.				
To the within To the comple	Me	29b. Signature and title of certifier	29c. License number D378011		Date signed (Month) [ay 21, 20]	
le		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Amit Rajvanfhi 121 Congressional		1D 20852	Suite #40	)9
Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

07-03451 Junior Bennett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ May 5, 2007 Bennett Junior 1715 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 8268 Canning Terrace Greenbelt 8. Date of Birth(MM/DDYXYY) 9. Birthplace (State or Foreign Jamaica 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Director 44 December 9, 579-98-3657 1X M 2 F Country) Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Washington, DC 1 X Yes 2 No 28a-f show DC Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20011 USA 5 5122 7th St. NW 238 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married Armed Forces' 2 X No Yes Black If Yes, Give Year Yes 2X No specify: Specify Widowed 4 Divorced "natural" à 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ nf of Health and Mental Hygiene.

1: If item 27 is marked other than "
other traumatic event, the Medical. 21215-0036 11th Jockey Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pear1 Cunningham Bennett 0swald æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bennett/ Mother 5122 7th St. NW, Washington, DC 20011 timore, MD Pear1 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 1 X Burial 2 Cremation 3 crematory or other place) Removal from State Harmony Memorial Park 05/18/2007 | Landover, Maryland tant: Donation 5 Other Specify: 21. Signature of Funeral Service License 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW, Washington, DC 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound of Head Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cauce. Enter Underlying Cauce (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed andtran Physician/Medical UNPENDED AMENDED the attending physician led for use as the burial The law requires that the death certificate be Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by t be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? 2 No Yes 2 Yes he Hospital or Attending Physician: The in 24 hours after death.

In Funeral Director: After this certifica pletely filled in by the funeral director, pa 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other<sub>4</sub> Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject shot self Natural FOUND: Yes 2 V No Pending May 5, 2007 1730 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 8268 Canning Terrace, Greenbelt, MD (Specify) Single Family determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) May 6, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Da

Registra

Day, Year

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32 Registrar's Signatur

State of the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 May 20 10:20a<sup>™</sup> Doris A. Bantz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 419 Walnut Grove Road Essex Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb. 23, 1938 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 5 F 213-34-4147 69 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Essex MD Baltimore 1 □Yes 2 No Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or? 419 Walnut Grove Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary McCormick Co. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Dimick Dora Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Walnut Grove Road Baltimore MD 21221 William Bantz / husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 5/25/07 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GRANULOMATOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ OBSTRUCTIVE 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIABETES Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ Manaer of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 □ Yes 2 □ No Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, 32. Registrar's Signature Year State MAY 2 3 2007

Registrar

			1 - For State State Registrar		tificate of Death	Reg. No	007 16663
ï	Physicia	an	1. Decedent's Name (First, Middle, Last)		Mon		
	/Medic	al	4a. Facility Name (If not institution, give street and number)	Lee Bra	andon, Jr 5  4b. City, Town, or Location of Death	21	2007 07:45 aM
je.	Examin	er	Sinai Hospital		Baltimore		NA
3	Funeral Director		212-40-2570 <sup>1</sup> ⊠ <sup>M</sup> <sup>2□</sup> F	(In yrs. last birthday) 64 Yrs.	Months Days Hours Min. (Mor	of Birth hth, Day, Year) -8-194	9. Birthplace (State or Foreign Country)  M D
	land ow t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Mary a-f sho ffied a	tor	MD NA	Baltimo	ore		XXYes 2 □ No
	th the or 28a e noti	Direc	10e. Street and Number		10f. Zip Code	10g. Citiz	zen of What Country?
	s 23a nust b	ral	3607 Labyrinth Road		21215		S A  4. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes, Give Year or Dates:	)	Vas Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican, e l □ Yes 2 🌠 No Specify:	tc.)	Black, White, etc.  Specify: Black
ς Ο	72 ho 'natur dical I	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kin	nd of Business/Industry
Baltimore, Maryland 21215-0036	within ene. than '	Completed by	Elementary/Secondary (0-12) College (1-4or 5+	NA Pai	nter		Church Hospital
ام 2	e filed al Hygi other vent, t	Be Co	10th grade  17. Father's Name (First, Middle, Last)	1471	18. Mother's Name (First, i	Middle, Maiden S	Surname)
ylar	Menta arked artic ev	To E	Robert L. Brandon, Sr		Jessie Le		
Mar	12 sho hand 7 ism traum		19a. Informant's Name/Relationship (Type. Print)  Helen F. Brandon-Wife		g Address (Street and Number or Rural Route		
٠ ف	s 1 and F Healf tem 2 other		20a. Method of Disposition		O Clareway Apt 8 M sition (Name of natory or other place)  Date		cation - City or Town, State
E	Pages nent of hant of hant. If ite		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Cemetery 5-25-20	07 Lans	sdown, MD
Salti	permit. Departmitimportal		21. Signature of Funeral Service Licensee			ch West	
	6 2 5 6 9		23a, Part1. Enter the disease, or complications that caused	the death. Do not out	4300 Wabash Aven		
	Physician		shock, or heart failure. List only one cause on each line		1 :0	nory unest,	Approximate Interval Between Onset and Death
	/Medical			consequence of):	· ·		
	Examiner	_	Sequentially hat conditions,	consequence of):	cardiovascular di	ceen-	
7	uted Insit	Examiner	Sequentially his conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Consequence on.	Dasely mellitus		
o,	tificate be executed g physician and as the burial-transit	Еха	resulting in death) Last  C.  Due to for as a	consequence of):	7 ( 00 ) 11 000 ( 100		
68760,	ate be	edical	d				
	certific ding p		IF FEMALE: 23c. If yes, outcome p	of pregnancy		2	23d. Date of delivery
Division or Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	2 ☐ Fetal death 3 ☐	]Ectopic pregnancy ] Other (specify)		Month Day Year
۳.	that the	/ Ph	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause given in Part I. 236	e. Did tobacco us	se contribute to the cause of death?
rds	equires en sign	q pa	Preixes strike			1 Yes 2	No 3 Probably 4 √ nknown
9 0 0	law re as bee	Completed by			248	u. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>	: The cate h				1	performed?/ Yes 2 No	death? 1 ☐ Yes 2 ☐ No
<u> </u>	sician certifi	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatier	at 2 MER/Outpatien	26. Place of Death (Check t 3 DOA Other: 4 Nursing Home 5		N TOU (0 Y)
0	g Phy er this eral d	n: To	27. Manyler of Death 28a. Date of Injur	/ 28b. Time of	4 Nursing Home 51	scribe how injury	
Sio	endin eath. or; Aff	atio	2 Accident investigation	Total injury	M 1 Yes 2 No		
	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of injurbuilding, etc	y - At home, farm, str (Specify)		ation (Street and or Town, State)	d Number or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner star	examination and/or in	n occurred at the time, date and place, and due vestigation, in my opinion, death occurred at th	to the cause(s) e time, date and	and manner as stated. place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number	1 1	e signed (Month, Day, Year)
			Boenying P Weels	1M-D	D19873	3(.	23/07-
	5		30. Name and address of person who completed cause of de BOONYUNG P THANA, M.D.			AITLAAN	REMINDINE
	2		DOCINACIO & (VIVILL'IN-1)	3336 KC	CICIO LOWIN IND 1)	TULLIMO	いい、ハウナイナー

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State 25 Maryland / Department of Health and Mental Hygiene [] [] ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Brucks 11:28 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death pk.L/ Baltimure 2 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 13-62-247 1**A** M 2□ F Director land Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County rei', or items 23a or 28e-f ehow Examiner must be notified at 10d. Inside City Limits Funeral Directo 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No ģ Specify: 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use religed).

Machine Operation other then "natur 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Operator** Name (First, Middle, Last) Be 18. Mother's Name (First, Middle. Pages 1 and 2 should be ment of Health and Mental ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 20a. Method of Disposition 0 1 ■Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee eral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): Examiner 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed and Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.0. this certificate has been signed by the rail director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 20 ER/Outpatient 3 DDA 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
May 23, 2007 000 38026 30. Name and address of person who completed se of death (Item 23a) (Type, Print) 1C.L .0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, 27 per dr., 8867, 05/23/07dhb.

Reg. No. 1 - State Registrar Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 04 /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 ine 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Number Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**√**M 2□ F Director Mary land sidence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show must be notified 1 Xes 2 No Funeral Director timore 10e, Street and Number 10g. Citizen of What Country? ō 23a rmaine 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Completed by Black Specify: 3 Widowed 4 Divorced "natural" other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) ectrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be is marked 2 stevenson -19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 mrock Aue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot once, 101 Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Eun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** 1000 disease or condition resulting in death) /Medical Due to (pras a consequence of): Examiner Equantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine hurial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician The law requires that the death certificate be Completed by Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) the s 9□Unknown 9 Unknown ned by the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. MIN 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an was and autopsy performed? Yes 2 No has page 2 certificate 1 Yes or Attending Physician: 25. Was case referred to predical examiner?
1 ☐ Yes 2 ☐ No director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ٩ 2 ER/Outpatient 3 DOA 5 Residence this 6 ☐Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Iniury after death. 1 🗌 Yes 2 ☐ No 2 Accident ouid not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mpnth, Day, Year) TO 5/15/ 26656 0 of person who completed cause of death (Item 23a) (Type, Print) JUNPOLES RO 30. Name and addre BULT MORE JORGE CAUDERON 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day MINDY 2007 /Medical BILKER MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERSITY OF MD MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 💢 F Director 201-44-9858 07/16/1952 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 XNo MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 11710 OLD GEORGETOWN ROAD, #1511

Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If Idem 27 is marked other than "natural", or Items 23 ant: If Idem 27 is marked other than "natural", or or other traumatic event, the Medical Examiner must Funeral 20852 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: WHITE 3 ☐ Widowed 4 🛣 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIVISION DIRECTOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STANLEY ဥ **BLOOM** BEATRICE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STANLEY BLOOM / FATHER 1151 HELLERMAN STREET, PHILADELPHIA, PA 19111
ce of Disposition (Name of Date 20c, Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MONTEFIORE CEMETERY 05/20/2007 | JENKINTOWN, PA 21. Signature of Funeral Service kinenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY EDEMA WEEKS /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **WEEKS** Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit COAGULOPATHY 6 WEEKS Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical FACTOR XI DEFICIENCY 6 WEEKS 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☑ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MULTIORGAN SYSTEM FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 21 No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica nours after death.

neral Director: After this certific
filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 2 3 2007

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32. Registrar's Signature

22

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

BACTIMORE

State of Maryland / Department of Health and Mental Hygien@ Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Genevieve Corbett Covolo 2:30AM 2-2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fairhaven Health Care Center Sykesville Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 15, 1914 Birthplace (State or Foreign Country)
 NC **Funeral** Months Days Hours 1 □ M 2 □ F 128-30-2001 92 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir then "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Carrol1 Sykesville Director 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 Funeral USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be tiled within 72 hours after Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iter any injury or other traumatic event, the Medical Eventina once. 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Chemistry Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Z. Corbett Genevieve Pearsall Jones 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Hamlin (Executor) 3421 Cotton Top Court, Fairfax, VA 22033 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation | 5/23/2007 Sykesville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit Exam Division of Vital Records, P.O. Box 68760, arphiDue to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 🗌 Yes 3 Probably 4 Unknown peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: ours after death. leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 12 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 29b. Signature a propertifier 29c. License number 29d. Date signed (Month, Day, Year) D0059054 5/22/7 13 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7200 Third Avenue, Sylcerville, MD 21784 Anna Sarante, 4.D. 31. Date filed (Month, Day, Year) 🗷. Registrar's Signatu State Registrar MAY 2 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 05 2007 12:30 A M Edward Carver /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Alice Manor Nursing Home Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 3 M 2 □ F 84 Director 216-18-3190 Feb. 4, 1923 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5916 Seward Avenue 21206 TISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 21 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 📉 No Specify: Completed by 3 ☐Widowed 4 ☐ Divorced Year or Dates: event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk permit. Pages 1 and 2 should be filed Department of Heath and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event. tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Artie Shaw / Guardian 10 N. Calvert Street; Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 05/24/2007 Mount Zion Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home, P.A. la 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,€ and resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed autopsy perform No No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 🛛 No 1 🔲 Inpatient Other မ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar

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State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

			For State Registrar	State	of Marylar	-	artment of H rtificate of I		•	giene Reg. No	07	16669	
, aş	Physici		Decedent's Name (First, Middle		ny Caugh	1an			2. Date of De Month	Day 21, 2007	Year	3. Time of Death	
	/Medio		4a. Facility Name (If not institution			Tan	4b. City, Town, or	Location of Dea		4c. County		10:14PM <sup>™</sup>	-
			9805 Con	necticut	Avenue		Ke	nsingto	n		Mont	gomery	
	Funeral Director		5. Social Security Number <b>276–42–0660</b>	6. Sex 1 ☐ M 2 <b>X</b> i	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Bir	ay, Year)	Coun		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				1	0d. Inside City Limits	_
	Maryl f sho ied al	ō	Maryland M	ontcomer			V	mainata	-			1 □Yes 2 No	
	r 28a	Directo	10e. Street and Number	ontgomer	У		10f. Zip Code	ensingto	111	10g. Citizen of V	What Coun	itry?	
	th with		9805 Con	necticut	Avenue			20895		Uni	ted :	States	
2-00-0	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ied Armed 1 ☐ Ye If Yes,	ecedent Ever in U Forces? es 2 X No Give or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎛 No	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White,		
0-0171	filed within 72 ho Hygiene. hther than "natur ent, the Medical I	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)		e (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of w	orking	16b. Kind of Bu			
ט ס	filed Hygi other ent, tl	ပို	17. Father's Name (First, Middle,		<u> </u>	пошен	akei	18. Mother's Na	ame (First, Middle	·			-
land	should be to the Mental I s marked of umatic eve	To Be	Andrew Kaufer					Gertrud	e Sole				
ary	shou and M s mar	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street			er, City or Town,	State, Zip	Code)	-
lore, M	Pages 1 and 2 nent of Health a tnt: If item 27 is try or other trai		Kevin Caugh1  20a. Method of Disposition  1 □ Burial 2 【**XCremation	3 □Removal fro	20b.	Place of Dispo	Connection  consistion (Name of matory or other place of matory)	i		ington, 20c. Location -		1and 20895 own, State	
Dallimor	+ + + + + -		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		C	remato:	rium Inc.	20	007	Bethe	sda,	Maryland neral Home/	ŗ
מ	permi Depar Impor any Ir		2.5.	30_	M008	896 B	ethesda-C ethesda,	hevy Ch Marylan	ase Inc d 20814-	17557 W	iscor	nsin Avenue	,
,0070	Cate be executed / Medical Examiner und the build-transit the build-transit the build-transit was the build-transit with the build-transit was the build-t	dical Examiner	23a. Part 1. Ent fr the I sease, or shock, or heart filure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Licease or high.) that initiated events resulting in death) Last	a. Gas Due b. Due c	stric Car to (or as a consect to (or as a consect to (or as a consect to (or as a consect	quence of):		gj saeti de said.				Approximate Interval Between Onset and Death	_
O. DOX OC	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	1 ☐ Liv 4 ☐ Pr	outcome pf pregn ve birth 2 Pet regnant at time of nknown	al death 3[	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	1			te of delive	ery Day Year	
ecords, r	law requires that las been signed b 2 should be deta	by	Part II. Other significant condition	ons contributing t	o death but not re	sulting in the u	nderlying cause give	en in Part I.				ne cause of death?	
_	sician: The law re certificate has bee rector, page 2 sho	Completed							24a. Was auto perfo 1∐ Yes	psy orm <u>ed</u> ?	prior to cor death?	psy findings available mpletion of cause of	
VII	sician certifi rector	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:			ot 3 🗆 DOA Othe		eath <i>(Check only c</i>				_
0 1101	To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification: To	27. Manner of Death 1 X Natural 5 □ Pendin 2 □ Accident investi	g 28a. Da gation (A	☐ Inpatient 2☐ ate of Injury flonth, Day Year)	28b. Time o Injury	f 28c. Injur	4 🗀 ivursing	Home 5 Resi	idence 6 □Oth how injury occur		y)	
	ospital or Attendi hours after death. uneral Director: A ly filled in by the fi	Certific	3 Suicide 6 Could 4 Homicide determ	inod   206, FI	ace of injury - At h uilding, etc. <i>(Sp</i> ec	nome, farm, sti ify)	reet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Number,	
	To the Hospital or Attenc Within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical one)	Examiner: On the	the best of my kn e basis of examin nanner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	pinion, death oc	ce, and due to the curred at the time	, date and place,	and due to	the cause(s)	_
	With Conf	Σ	29b. Signature and title of certifie		00		29c. License	e number		29d. Date signe	d (Month,	Day, Year)	
	0		Joy 1	+ WI	0	no		258		May	22,	2007	_
	10		30. Name and address person			, ,	,	umbic	Marrel 1	21044			
	Sta		Gary Wilks, M.  31. Date filed (Month, Day, Year)	3	Registrar's Sign	ature _		инота,	ratytand	21040		<del></del>	-
	Registr	rai	MAY 2 3	7001 B	STATE OF	1	The same of the sa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 11:15 PM Evencio Castro-Diaz May 18, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Casey House Montgomery Derwood 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 M 2 □ F Pureto Rico 85 Director 582-40-1855 05/15/1922 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Hean 23 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Brookeville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pureto Rico 20833-2405 Epstein Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1. Yes 2 No Specify: \$ 3 Widowed 4 ☐ Divorced White Puerto Rican Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Senate of Puerto Elementary/Secondary (0-12) College (1-4or 5+) Clerk Rico 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Juan Castro Vazquez Aqustina Diaz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elba L. Castro/Daughter 2405 Epstein Ct. Brookeville, MD 20833-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State May 22 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Parotid Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed the attending physician and hed for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical tate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 20 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 2- Natural 1 ☐ Yes 2 ☐ No 2 Accident I Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Milliam Do 05-21-2007 H58032

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Cynthia M. Williams MD 1355 Picard Dr. Rockville, MD 20850

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month Physician May 21, Peter F. DeBoy 7:15 P.M /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10XM 20 F 215-10-3257 Director 87 August 8, 1919 Maryland Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits other then "naturel", or iteme 23a or 28a-f ehow rent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane CR515 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No
If Yes, Give
Year or Dates: 1941-44 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Import/Export permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ferdinand DeBoy Elizabeth Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma E. DeBoy 715 Maiden Choice Lane CR515; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑Other (Specify Entombment Loudon Park Cemetery 5/24/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Tanda 1630 Edmondson Avenue; Catonsville, Semmer MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 NO Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: P 1 Yes 2 No 3□ DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending 1. Natural 5 Pending ours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours or 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 00020040 aus MA aiden Chorce Can Catenrille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alle 10 2. Registrar's Signature 31. Date filed (Month, Dav. Year) State Joseph . Registrar

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Division or Vital Records, P.O. Box 68/60,	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.
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	Please	Type or Prin				•	•	le.
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1	. Decedent's Name (First, Middle, La	st)	06	i incate of	Deatti	2. Date of De	Reg. No.	3. Time of Death
Physician /Medical =	Antonio	Di	Cerbo			May Month	19, Day 200	7 7:23 а м
	a. Facility Name (If not institution, give		-1 C+		or Location of Death		4c. County o	of Death
5.	Baltimore-Washin Social Security Number 6.8		al Center		Burnie	8. Date of Bir	th	e Arundel  9. Birthplace (State or Foreign
Director	180-54-0788	M 2□F	43 Yrs.	Months Days	Hours Min.	(Month, Da	23,1963	Country) Italy
0	Sual Residence of Decedent  0a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Maryl strength	Maryland Anne	Arundel	P	asadena				1 ☐ Yes 2 No
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ter death w ritems 23a siner must Funeral	7902 Wiltshire	12. Was Decedent E	Ever in ILS 13		1122	ecify Ves or No	U.S.A	- American Indian,
by by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates:	lo	If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ean, Mexican, Puerto Specify:	Rican, etc.)	Black Specify:	, White, etc.
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Mar 12 sho th and 7 is m traum	19a. Informant's Name/Relationship ( Donna M. DiCerb			-	re Court,			
Te, I	Donna M. DiCert Oa. Method of Disposition	o (wile)	20b. Place of Disc		1	Date		City or Town, State
antimor rmit. Pages partment of portant: if it y injury or o	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1	of Faith	, ,	4-07	Baltimo	re, Maryland
Deartit. Departit imports any injections.	21. Signature of Funeral Service Licer	1see Jan	ah I		olyniák F			yland 21122
Discriptor (	23a P. rt1. Enter the disease, or com hock, or heart failure. List only mediate Cause (Final	one cause on each lin	the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical	disease or condition resulting in death)		a consequence of).	1000	W		- <del>E</del> Q	3/43
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be de be de	art II. Other significant conditions of	contributing to death bu	at not resulting in the	undenying cause gi	ven in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
D 8 8 0			· · · · · · · · · · · · · · · · · · ·			24a. Was auto perfo 1 Yes	psy pr ormed? de	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2 M No
VITAL  ilclan: 1  certificat ector, pt	5. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Deat			
Phys rr this er this eral dir	1  Yes 2 No 7. Manner of Death	28a. Date of Injur	ry 28b. Time	SIK 3 DOA	4 □ Nursing Ho		idence 6 Other	
SION tending leath. tor: Afte the fune cation	1 □ Natural 5 □ Pending 2 □ Accident investigation		Year) Injury		rk? ]Yes 2□No			
To the Hospital or Attending Physician: The Within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	3 Suicide 6 Could not be determined	28e. Place of inju building, etc	iry - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location ( City or To	Street and Number wn, State)	r or Rural Route Number,
o the Hospi ithin 24 hour o the Funer ompletely fill Medical		nysician: To the best of miner: On the basis of and manner sta	examination and/or i					nner as stated. nd due to the cause(s)
Tot Tot Tot Com Com	9b. Signature and title of certifier	3 mi		29c. Licens	se number 33	>	40.4	(Month, Day, Year)
5 3	10. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print) 6 1-	on m	7 20	25 D	
State <sup>3</sup> Registrar	MAY 2 3 2007	32. Registra	ar's Signature	the s				

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29a. Certifier

(Check only one)

29b. Signature and title of certifier

Registrar

Cyratia M. Hilliamo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

H0058032

May 15,2007

Division or Vital Records, P.O. Box 68760,

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed physician ed by the a detached t After this within 24 hou To the Fune completely fi

Physician

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.

**Funeral Director** 

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Completed

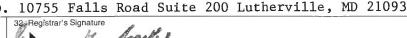
Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 25. Was case referred to medical examiner? 1 ☐ Yes Certification: To 27. Manner of Death 2 Acident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

1941

Dr. Eric Seifte, M.D. 31. Date filed (Month, Day, Year) State



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>007</u> May 22, Alexander T. Elieff 5:45  $A^{M}$ 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7201 Exeter Road Montgomery Bethesda If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

101 y 16, 1925 Egypt 7. Age (In vrs. last birthday) 6. Sex Months Days 1MM 2□ F 81 384-18-6011 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7201 Exeter Road 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give WWII Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Procurement Analyst NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Elieff Anna Yogun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy S. Holt/Daughter 2109 Cascade Road, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee 101346 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 Months Immediate Cause (Final disease or condition resulting in death) Metastatic Renal Cell Carcinoma Due to (or as a consequence of): Renal Cell Carcinoma 2.5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant

**Physician** /Medical Examiner

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within 24 hours a

**Physician** 

/Medical

**Examiner** 

Director

Completed by Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records.

P.O. Box 68760.

Certification: To Medical (

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 3 ☐Ectopic pregnancy 4□Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 X No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 M No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 May 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

364

Linda M. Burrell, M.D.

MAY 2 3 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

in the stand

2730 University Blvd. #400, Wheaton, MD 20902

	·	1 - State Amend #23a&23P11 Per Ph	land / Departure G867	artment of Hea	alth and Me eath	ntal Hygien Reg. N	<u>e</u> 007	16676			
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		The Johns Hopkins Hos	pital	Baltim	love (	ity	NA				
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		Under 24 Hrs. 8 fours Min.	Date of Birth (Month, Day, Yea.	9. Birthp	lace (State or Foreign			
Director		215-22-6783 1 <sup>1</sup> M 2 X F	82 Yrs.	Lilonato Bayo		0-21-19		Va.			
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ural'	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10- 0-	t1-11-10		140					
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l 2 st		19a. Informant's Name/Relationship (Type, Print)  Doris Worthington Fri∈	4.	19 Address (Street and t 114 Lothia		_		21212			
ss 1 and 2 should of Health and Men item 27 is marke other treumatic			Ob. Place of Dispo		Dat		Location - City or To				
00-		20a. Method of Disposition 1	cemetery, crei	natory or other place)							
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permit. Departn Importé any inju		21. Signature of Funeral Service Licensee	)	2. Name and Address of		arch F.					
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	5					performed? 1 ☐ Yes 2 ☐ N	death?	2 🗆 No			
ysicien: The is certificate hi director, page	Be (	25. Was case referred to medical examiner?		26.	. Place of Death (t	Check only one)					
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the Find 24 the Find Find Find Find Find Find Find Find	Medical	one) and manner stated.									
With To t	≥	29b. Signature and title of certifier		29c. License nui	mber	29d. D	ate signed (Month,	Day, Year)			
		► MSHZ11		KF.	000	5	105/07				
		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	V		/ - / /				
		Maulannad DATTI		h wolf st	Baltin	nore m	D 2128	7			
Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's 3	Signature					•			
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			For State Registrar	State of Mar		artment of I ertificate of		, ,	iene g. No. 20 (	07 16677				
Physic		an	1. Decedent's Name (First, Middle, Last)		R.		ris	2. Date of Deat Month	Day Y	3. Time of Death				
	/Media	al	David  4a. Facility Name (If not institution, give street and number)		κ.			5	19 20 4c. County of					
1	Examir	ier	202 S. Robins		t		4b. City, Town, or Location of Death Baltimore		NA	Death				
	Funeral Director		5. Social Security Number 6. Sex 218-48-2161	7. Age (	(In yrs. last birthday 60 Yrs.	Months Days			Year)	9. Birthplace (State or Foreign Country) Md.				
	and W		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits				
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	th the or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?				
	9th wi	raic	202 S. Robinson			21224			US	SA				
936	72 hours after deeth with the Maryland "naturel", or itema 23a or 28a-f ahow alcal Exarcit er inset the rediffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ev Anned Forces?</li> <li>Yes 2 No If Yes, Give Year or Dates:</li> </ol>	ver in U.S. 13	Was Decedent of I If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. Black				
21215-0036	72 hor	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dec	edent's Usual Occu	pation	deina	16b. Kind of Busi	ness/Industry				
2		Completed	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+)		e kind of work done DO NOT use retire abled	ed)	ixiiig	NA					
22	filed v Hygie other t		17. Father's Name (First, Middle, Last)		D1,	- Japica	18. Mother's Na	me (First Middle I		1				
an	should be f nd Mental h marked of	To Be	Vernon	I	Matthews	5	18. Mother's Name (First, Middle, Maiden Sumame)  Millie Wright							
Maryland	2 should and Men is marke		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mai	ling Address (Street	t and Number or R	ural Route Number	City or Town, St	tate, Zip Code)				
	1 and 2 Health		Geneva Stokes	Garris 1		202 S. R	Robinson							
Baltimore,	8 4 = 0		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ Real Burial Donation 5 □ Other (Specify)	emoval from State	20b. Place of Disp cemetery, cri Crowns	osition (Name of ematory or other pla SVILLE V	et. 5-2	24-07		ity or Town, State sville, Md.				
Balt	permit. Page Deportment of Important: If any njury or once.		21. Signature of Eyneral Privice License	ө		22. Name and Address 1101 E.	North	March B	T.H. Ea	st e, Md. 2120				
68760,	Physician /Medical Examiner  buysicien and burial-transit sthe purial-transit	hysician/Medical Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a o	consequence of):  Consequence of):  Consequence of):  Consequence of):		pusia			Approximate Interval Between Onset and Death  3 W  3.5 9				
Box (death certil	death certil a attending od tor use a		hysician/Medic	nysician/Medic	hysician/Medic	hysician/Medic	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date Month
	es thet igned t	by P	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did tot		oute to the cause of death?				
Division of Vital Records,	e law requires thet the has been signed by th je 2 should be detache	Completed						24a. Was a	n 24b. We	Probably 4 Unknown  are autopsy findings available or to completion of cause of				
a	The ete							perform 1 Yes 2	No 1	ath? ☐Yes 2☐No				
₹	s certil	o Be	25. Was case referred to medical examiner?  1 Tes 2 No	ospital:	2∏ EB/Outpati	2 DO4 Ot	har	ath Check only on		(0. 4)				
٥	ng Phy ter this neral c	<b> -</b>	27. Manner of Death	28a. Date of Injury (Month, Day)	of Injury 28b. Time of 28c. Injury at				ow injury occurred					
Sior	Attending Physician: r death. sctor: After this certition by the funeral director.	atic	1 Natural 5 Pending 2 Accident investigation	(Month, Day )	rear) Injury		Yes 2 □No							
Divi	al or Att s after d il Diract id in by	27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Jnjury M 1   Yes 2   No 28b. Injury at Work? 1   Yes 2   No 28b. Place of Injury at Work? 28b. Place of Injury at Work? 28b. Place of Injury at Work? 28b. Place of Injury at Work? 28b. Time of Jnjury at Work? 28c. Injury at Work? 28b. Place of Injury at Work? 28b. Place of Injury at Work? 28c. Injury at Work? 28b. Time of Jnjury at Work? 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurre								or Rural Route Number,				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edicai	29a Certifier (Check only one) Certifying Physics Certifying Physics (Check only one)	er: On the basis of e and manner state	xamination and/or i	ith occurred at the ti nvestigation, in my	ine, date and plac opinion, death occi	a, and due to the edurred at the time, do	tuce(s) and man ate and place, an	or as stateu. d due to the cause(s)				
)	To t To t	Σ	29b. Signature and the of dertifier	umur		29c. Licen	2160		5/21/2	(Month, Day, Year)				
	1+1		30. Name and address of person who co	Truet b	HET M	ORE, MI	21201	PETR	HAUSN	ER IND				

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 3 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Edward Goldwire 4:25 AM 19 2007 /Medical . Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Medical Daltimore Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number Date of Birth (Month, Pay, Year) 10/06/1934 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

FL 6. Sex **Funeral** Days Months Hours 262-46-0958 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23e or 28e-f ehow the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9017 Meadow Heights Road 21133 USA permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene importent: if item 27 is marked other than "naturel", or items 23e any hijury or other traumatic event, the Mudical Examples page. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. lf Yes 2 □ No If Yes, Give Year or Dates: 1957-1959 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) General Contractor Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Goldwire Rosalee Hogan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Goldwire/Brother 9017 Meadow Heights Road Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 21 20c. Location - City or Town, State 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, Maryland Inc. 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Cremation and Funeral Alternatives MOILLA 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 hours **Physician** Cardiac arrest /Medical Due to (or as a consequence of): 4 hours Examiner neumoshows Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine sicien and burial-transit ruche Pulmoney Disease or Attending Physician: The law requires that the death certificate be executed MONIC that initiated events resulting in death) Last Due to (or as a consequence of) ng physicien as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by abetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has ral director, pege 2 autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XI patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After thi 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 5 Pending investigation Natural r death. 1 ☐ Yes 2 ☐ No efter death Director: / 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours eff To the Funerel Di completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

29c. License number

Guilford Ave

29d. Date signed (Month, Dey, Year)

Balt

2007

			1 = For State Registrar	State of Marylar		rtificate of l		, ,	g. No.2	16679	
*	Physici /Medic		Decedent's Name (First, Middle, Last  Joan Mar:					2. Date of Death	17 207	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	•	4c. County of Dea		
	(n. juni		Balto-Wash Media  5. Social Security Number 6. Se		In an in tenth of a co	Glen If Under 1 Year	Burnie	8. Date of Birth	Anne Ai		
	Funeral Director		209-24-7892 Usual Residence of Decedent	x 7. Age (In yrs. 73	Yrs.	Months Days	Hours Min.	Jan. 28		thplace (State or Foreign ountry) nnsylvania	
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits	
1213-40036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at		to	Maryland Anne A	rundel Mi	llersvi	i11e				1 ∐Yes 2 📉 No	
		Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
th with	th with		611 Waterwheel La	ne Apt 31		21108			U.S.A	Α.	
	tems term	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
Maryland 21215-0036 nd 2 should be filed within 72 hours after tith and Mental Hygiene. 27 is marked other than "natural", or its rtraumatic event, the Medical Examine		by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		1 □ Yes 2 🏋 No	Specify:		Specify:	White	
5	72 h "natu dical	etec	15. Decedent's Edu (Specify only highest grad	cation 'e completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ting 1	16b. Kind of Business	/Industry	
7	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) N/A				1	ousen Vol	low Cobool D	
1	e filed vall Hygie other i		17. Father's Name (First, Middle, Last)	N/A	Direct	cor of Fo		e (First, Middle, M		ley School D	
5	ould be Mental narked o	To Be	Помен	Walter	Ster	, l	Henriet	-ta M	larie l	Muller	
, .	2 should and Men is marke aumatic	-	Harry 19a. Informant's Name/Relationship (T						City or Town, State,		
2	1 and 2 Health a em 27 is other trau		Richard K. Garis	(Son)	611 V	Vaterwhee	1 Lane Ar	ot 31 Mi1	lersville	Md 21108	
ָ ט			20a. Method of Disposition	20b. I		sition (Name of matory or other place			20c. Location - City or		
=	Pages nent of nnt: If its iry or o		1 ☐ Burial 2 XCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify	removal from State		Cremator		3/07 B	altimore,	Maryland	
Dakilliole,	permit. Page D. partment of Important: If any injury or or ce.		21. Signature of Fundal Service Licens		22	2. Name and Addres	ss of Facility		lome, P.A. a, Maryla		
		23a. Part. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dear	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	l <b>a,</b> Maryla) est,	Approximate Interval Between		
	Physician		Immediate Cause (Final							Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a consec	quence of):	140 //	7				
	Examiner			LIVER	CIA	PITZOPATI LIAOSIS					
=	n #	ner	it any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of).						
p	nd rransi	Examin	Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
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00100	tificate be executed ig physician and as the burial-transit	edical		d							
о К			IF FEMALE:	23c. If yes, outcome pf pregn	ancy						
2	requires that the death cert een signed by the attending hould be detached for use a	Physician/N	in the past 12 pronths?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
į	the de	ysic	1 □ Yes 2 No 9 □ Unknown	9□Unknown	death 3L						
L	that the dended by the a		Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?	
2	quires n sign	d by						1 ☐ Ye	s No 3 P	robably 4 Unknown	
necolus,		Completed						24a. Was an	24b. Were a	utopsy findings available	
2	The law ate has b	E C						autopsy perform 1□ Yes 2	y prior to	completion of cause of	
אונשו	(0)	Ø.	25. Was case referred to medical				26. Place of Deat	1  Yes 2 th (Check only one	/\-	5 22 110	
>	S S	.o	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	] ER/Outpatier	nt 3 DOA Oth	or:		nce 6 □Other (Spe	ecify)	
5		Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Worl	y at	28d. Describe ho	w injury occurred		
DISION	Attending r death. ector: After by the fune	atio	Natural 5 Pending investigation	(	,/		Yes 2□No				
2	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		eet, factory, office		28f. Location (Str. City or Town	reet and Number or Fi , State)	lural Route Number,	
3	ital or rrs aft ral D										
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	s stated. le to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon		
			Assa-	m		D4.	3977	V	Non 17	- 200+	
	S		30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type,	Print)					
	4		Chrok bregin	in 301 Hose	italo	ero, We	n Bum	E my	2106	- 2007	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	de		1			
	Regist	ar	MAYZJZUU	1 Salation of the	Contract of the second	G. Carrier					

		1 - For State Registrar	State of I	Maryland / De	partmer ertificat			nd Menta	al Hygien	21111/	166	80
	2.	Decedent's Name (First, Middle, Last)     2. Date of Death								3. Time of De	eath	
Physi /Med		BISIA ADDATSOD HALAV								6:15	АМ	
Exam	iner	4a. Facility Name (If not institution, gr		er)	4b. City,	Town, or	Location of	Death	4	c. County of Deat	n	
	4	Wilson Health Car 5. Social Security Number 6.		Ago //g use leaf high-		ither	sburg	4 Hrs. La		Montgome		
Funera Directo			1 M 2 ₩ F	Age (In yrs. last birtho	Months	Days	Hours	Min. (Mo	te of Birth onth, Day, Yea	r) Co	nplace (State or F untry)	
(s)		Usual Residence of Decedent		100				Apr	il 9, 1	1907 Mass	achuseti	ts_
rylan		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City	Limits
Ba-f s	Director	Maryland Montgome	ery	Gaithe	rsburg						1 (Yes 2	□No
with th	Dire	10e. Street and Number			10f. Zip	Code			10g. C	Citizen of What Co	untry?	
s 23s	20	301 Russell Avenu		15-115			877			ted Stat		
ter d	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Tyes 2	s?	If Yes, spe	cify Cubar	spanic Origi n, Mexican,	in? (Specify Ye Puerto Rican,	etc.)	14. Race - Ame Black, White		
Urs al	b	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Date:	λ.	1 🗆 Yes	2X No	Specify:			Specify: Wh	ite	
Maryland 21215-0036 at 2 should be filed within 72 hours after death with the Maryland and Mental hygiene. by an and Mental hygiene. 27 is marked other then "naturel", or Items 23s or 28s-f show traumatic event, the Madical Examiter must be recitived.	Completed	15. Decedent's 8 (Specify only highest gi		16a. De	cedent's Usua	al Occupa	tion	of working	16b.	Kind of Business/	ndustry	
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tore, Maryland 2 ges 1 and 2 should be filed to Health and Menial Hyg If item 27 is marked othe or other traumatic event,		Cynthia Haley Dra									ip Code)	
S 1 ar	0.3	20a. Method of Disposition	per/Daugn	20b. Place of Di	sposition (Nar.	me of		Date		FL 32550 Location - City or	Town, State	
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프 글론본글		21. Signature of Funeral Service Lice										
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Physician /Medical Examiner physician and physician and the priral-transit	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a Due to (or a c.	is a consequence of):						merés)	Approximate Interval Between Sharet and Deg	ath
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending priys age 2 should be detached for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic pr 5 □ Other (sp					23d. Date of deli-	∕ery Day Ƴea	ır
s that	y P	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying c	ause giver	n in Part I.	23	e. Did tobacco	use contribute to	the cause of deat	th?
Vital Records, sician: The law requires t certificate has been signerector, page 2 should be continued.	Completed by	Osteepara	ex						1 🗆 Yes 2	2 ☑No 3 ☐ Pro	bably 4 Dunk	nown
BCC law re	plet	Saevaldecubities. 24a. Was an							24b. Were autopsy findings available		ulable	
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ita ian: ortifica ctor.	BeC	25. Was case referred to medical examiner?					26. Ptace o	f Death (Chec		0 11165	20,140	
hysic his ce	2	1 ☐ Yes 2 ☑ No		tient 2 ER/Outpa	tient 3 DO	Other	4 Nurs	ing Home 5	Residence	6 ☐Other (Spec	ify)	
on of ding Phys After this funeral di	on:	27. Manyrer of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time lay Year) Injur		28c. Injury : Work?	at ?	28d. De	scribe how inju	ary occurred		
Division of Vital to a variending Physician: after death. Director: After this certification by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	ne -		М		es 2 No					
Division of Attendate death Director:	ertif	4 Homicide determined	building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factory	i, office		28f. Loc City	ation (Street a or Town, Stat	nd Number or Rui 'e)	al Route Number	1
Division of Vital Re within 24 hours after death.  To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate in completely filled in by the funeral director, page		29a. Certifier 1 Certifying Pl	ysician: To the bed	t of my knowledge, de	ath occurred	at the time	date and	otace and des	to the error'	a) and manner	otatod	
To the Hospital within 24 hours. To the Funerel completely filled	edlcal	(Check only 2 Medical Example)	miner: On the basis and manner:	of examination and/or	investigation,	, in my opi	nion, death	occurred at th	e time, date an	nd place, and due	to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	0 '	, /	7 290	. License	number		29d. Da	ate signed (Month	Day, Year)	
)		HeRobert	Surse	was	us.	00	411	5	mo	ry 17, 8	2007	
4		30. Name and address of person who	completed cause of		pe, Print)	201	PU	RSBCL.	26, W	LUE 20	877	
St Regis	ate trar	31. Date filed (Month, Day, Year)	21	trar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Johnson Gregory May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Barriew Medical Hopkins (Pnter Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 14 M 2 □ F Director 51 02/02/1956 MD 216-68-4646 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 □ No Funeral Director MD Baltimore Baltimore City 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? 21217 800 W. Lexington Street Apt. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 23 If Yes, Give Year or Dates: 12€ Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Henry Johnson Ellen Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Cook/Cousin 518 Chestnut Hill Avenue Baltimore, MD 21218 20a, Method of Disposition 20c. Location - City or Town, State Chesapeake Crematory Inc. 2007

22. Name and Address of Facility 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Non-small cancel /Medical Due to (or as a consequence of): Examiner YERIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be execut Tobacco abuse Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 2 No Yes Vital or Attending Physiclan: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🔽 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Man/her of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Avenue

Eastern

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Anna Kappes 2:37 PM 2007 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10 Month | Days | 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 84 216.12.0705 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5700 Sharon Drive 21057 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: \ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 Divorced WI Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Bem Emma Link မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hough/daughter 5700 Sharon Drive Glen Arm, Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05.22.07 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Uncontrolled 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

burial-trar the use as signed by the a or Vital or Attending Physician: completely filled in by the funeral after death Hospital

**Funeral** 

Director

r 28a-f show notified at

d 2 should be filed within 72 hours after death with th and Mental Hygiene.
7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be i

1 and 2 should be Health and Mental

permit. Pages 1 and 2 Department of Health a

Important: If it any injury or o once.

**Physician** 

/Medical

Examiner

Maryland 2121

within 24 hours a

To the Funeral 6

State

29b. Signature and title of certifier

Day, Year)

Registrar

DHMH 17 Rev 1/2001

29c. License number

Do053568

Upper Charpeake

29d. Date signed (Month, Day, Year)

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

MMDSon MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 16683

		- For State			Certifi	icate of	Death					eg. No.			2 Time of Dooth
Physicia √Exami	an/ ner	Decedent's Name (First, Midd     NATHAN		DAV	I D		KARA			1	Date of Dea Month May 19, 2	Day 2007	Year County of		3. Time of Death 2224 hrs
		4a. Facility Name (if not instituti Sinai Hospital	on, give stre	eet and number)		4	b. City, Tov Baltimo		ation of	Death		4c.	County of		/A
Funeral		5. Social Security Number	6. Sex		e (In yrs. last t		If Under		f Under Hours	24Hrs. Min.	8. Date of Bi			Foreig	thplace (State or gn untry) PA
Director	L	173-46-7006	1 X M	2F	53	Yrs.					03/2	9/19	54		
any	<u> </u>	Usual Residence of Decedent  10a. State 10b. County	,		10c. City, To	wn or Locati	on								10d. Inside City Limit
nd show	اۃ	MD	N/A	Α	В	ALTIM			_			10 0'''	of 10/h	at Cau	
daryla 28a-f	Director	10e. Street and Number					10f. Zip C	ode			11.11	10g. Citiz	en of Wh	at Cou	nu y ?
the N 3a or otified		3710 CLARKS				40.144	. Decedor	2121	L5	n2 / Sner	cify Yes or N	0-	14. Race	S Amer	rican Indian, Black,
th with	Funeral	11. Marital Status  1 Never Married 2 x		2. Was Decedent Armed Forces?	)	IS. Wa	es, specify	Cuban, M	lexican,	Puerto Ri	ican, etc.)		White		
er dea		^	ivorced If Y	es, Give Year	X No	1	Yes 2 X	No s	specify:				Specify:	W	HITE
urs aft Itural' antine	d by	15. Decedent's Education (Sp	or	Dates:	npleted) 16	6a. Deceder	t's Usual O ost of worki	ccupation	(Give ki	ind of wo	rk done d)	16b. h	(ind of Bu	siness	Industry
15-0036 I filled within 72 hours after death with the Maryland I filled within 72 hours after death with the Maryland of other than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12	?)	College (1-4 or	5+)	MANA							Fl	JRN1	TURE
within within incr the Medi	티	17. Father's Name (First, Midd	e Last)					18.	.Mother's	s Name (I	First, Middle	, Maiden	Surname	)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	HAROLD	, 2001)			KAR	ABELL			CLAI	RE		ALTM/		
212 ould be I Ment is mark	പ	19a. Informant's Name/Relatio				19b. Mailin	g Address			ber or Ru	Philade	umber, C	ty or Tow	n, Stat	te, Zip Code)
MD d 2 sho lth and n 27 is aumati		MARSHA ROSI	<u>ENTHAL</u>	L / WIFE	20h Pla	986	O CLAI	RK ST	TREE		DHILA! Date	20c.	Location	- City c	9115 or Town, State
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Sis marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1		Removal from S	tate ANSH	emator Pispo emator Pi	<b>10.4.b</b> ce) <del>NHA</del> -	AITZ		05/2	1/2007				, MD.
Baltir permit. F Departme Importar		21. Signature of Funeral Servi	ce Licensee	е		22.	Name and A	Address of	† Facility		SOL LI	EVIN:	SON 8	k BF	ROS., INC.
<b>0</b> 80 4.E		23a. Part I. Enter the disease,		etions that source	d the death F	o not enter	8900	REIS	STFR uch as ca	STOW ardiac or	N ROAI respiratory	arrest, sh	ock, or he	VII eart	LE MD 212 Approximate Inter
ysician /Medica		failure. List only one cau	se on each	line.											Between Onset a Death
Examine		Immediate Cause (Final disea or condition resulting in death	_	ultiple Injurie											
		Sequentially list conditions,	b												
	Examiner	if any, leading to immediate cause. Enter Underlying Cau	se	e to (or as a con	sequence of):										
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8760, tificate be ng physic as the bur	N.	IF FEMALE: 23b. Was decedent pregnant i	n the	1 Live birth		2 F	etal death	3	Ectopi	c pregna	ncy		Month		Day Year
Box 68 e death certif the attending	sician	past 12 months?	Unknown		at time of dea	ith 5 (	other (Spec	cify)							
ision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificate that the death certificate has been signed by the attending vector. After this certificate has been signed by the attending the character forces areas 2 should the detached for use as	Phys	Part II. Other significant con		9 Unknown	ath but not res	sulting in the	underlying	cause giv	ven in P	art I.					to the cause of death?
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Of of ng Ph	D: T	27. Manner of Death		28a. Date of I (Month, Da May 18, 20	njury v.Year)	28b. Time of 2058 hrs	of Injury	28c. Injury	yatWor ′es 2.▼		28d. Descr Pedestria				
ion ttendi Jeath.	atio	1 Natural 5 2 ✓ Accident	Pending nvestigation		1		root factors		-		28f. Locatio	on (Stree	t and Nur	nber or	Rural Route Number,
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  The properties of the this certificate has been signed by the the state of the state o	Certification:	3 Suicide 6	Could not be determined	e 28e. Place of (Specify)	Injury - At ho	me, farm, st	reet, factory	y, office at	unumg, c	510.	l or Tou	m State			e, Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the control of the funeral physician and a second the control of the cont	cal Cel			in: To the best of		ge, death oc	curred at the	e time, da	ite and p	lace and	due to the	cause(s)	and mani	ner as	stated.
To th To th	Medical	29b. Signature and title of ce		and manner state	ed			c. License							(Month, Day, Year)
	2	29b. Signature and title of the		nus				O.C.N	M.E.			M	lay 20,	2007	
1		30 Name and address of pe	rson who c	ompleted cause	of death (Item	1 23a)									
,		Ling Li, MD Ass	istant Me	edical Exami	ner 111	Penn Str		imore, l	MD 21	201					
	Stat	31. Date filed (Month, Day, Y	(ear)	27.00	strar's Signatu	re	eds)								
Reg	intro	E VARE	3 200	7 Balance	The way of the	A. Carrier									

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

To the Hospital or Attending Pr within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

State Registrar 9106

2. Date of Death

мау 20<sup>Day</sup> 200<sup>Y</sup>7

7:20a м

4c. County of Death

Baltimore

8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) New York 9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes Ž∏No

10g. Citizen of What Country?

USA 14. Race - American Indian,

Black, White, etc. Specify: White

16b. Kind of Business/industry

own home

18. Mother's Name (First, Middle, Maiden Surname)

Angelina Spert

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

913 Seneca Park Road Baltimroe MD 21220 20c. Location - City or Town, State

> Rossville MD 22. Name and Address of Facility 300 Mace Ave. Baltimore MD

Connelly Funeral Home of Essex 21221

Approximate Interval Between Onset and Death year

23d. Date of delivery Month Vear

> 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of

autopsy performed? death? 1 ☐ Yes 2 ☐ No 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend PI line b, peri<sup>N</sup>D, g867,5/29/07 Certificate of Death

Red. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05:04 AM Marks Scott Bryan 21, 2007 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Center Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex **Funeral** Days Months Hours 1 XM 2 □ F July 28,1961 214-56-9904 45 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland 10d, Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1905 Adams Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify: þ 3 □ Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years 2 vears Crane Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Mary Lou Dorbit Fredrick John Marks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 is
any injury or other traus wife 1905 Adams Road, Dundalk, Maryland 21222 Wanda R.Manchego - Marks 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 25,2007 Dundalk, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypertensive carliouriscular disease **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s Jas autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1.∰Yes 2 No 1 🔲 Inpatient 2

ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 20063000 ND

State Registrar 31. Date filed (Month, Day, Year) -3

30. Name and addr

Sylvia Changers 7835 East point Mau Str 305 Balt, MD 2024 32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

and After this certificate af er death Hospital

use as the burial-tra been signed by the should be detached page 2 s director, funeral the f filled in by within 24 hours a

To the Funeral I

completely filled

**Physician** 

/Medical

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

other traumatic event, the Medical

is marked other than

ould be

es 1 and 2 should b of Health and Menta fitem 27 is marked

permit. Pages 1 & Department of He Important: If item any injury or other

**Physician** 

/Medical

72 hours after

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

Examine

Physician/Medical

Completed by

Certification: To Be

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number

29b. Signature and title of certifier M D

AWAIS MASOOD MD.

P- 19508

29d. Date signed (Month, Day, Year) 200 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AWAIS MATERIODD 31. Date filed (Month, Day, Year)

900 S CATONS AVE 32. Registrar's Signature

STAGNES HOSPITAL BALTIMORE MOZIZOG

MAT, 21

State Registrar



			1 - For Amend	State of M Item 8 per	laryland / Der f <b>h,g871,0</b>	partment of 1 712/07dhb ertificate of	lealth and M Death	lental Hyg	iene <sub>eg. No.</sub>	07	166	87
	Physici		1. Decedent's Name (First, Midd	11.11	M	Flyes	^	2. Date of Dea Month May	Day	2007	3. Time of 650	Death A M
}	/Medio		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, or	Location of Death	May	4c. Cour	nty of Death		
	Funenci		5. Social Security Number		enter ge (In yrs. last birthda	Cheve	If Under 24 Hrs.	8. Date of Birth	<u> </u>	9. Birtho	lace (State o	or Foreign
	Funeral Director		438-27-0177	1 <b>¼</b> M 2□F	37 Yrs.	Months Days	Hours Min.	11/10/1	969	· · · Cour	hingt	
	yland		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town or	,				1	10d. Inside Ci	•
	the Mar	Funeral Director	10e. Street and Number		Washi	ngton 10f. Zip Code			0g. Citizen o	of Mihat Cour		2 No
	th with	al Dir	918 Easter	rn Avenu	e	-	0019	0	( ).	5-1	4	
	ltems	uner	11. Marital Status  1 X Never Married 2 ☐ Ma	12. Was Decedent Armed Forces 1 Yes 2	?	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,		
3036	72 hours after deeth with the Maryland natural', or Items 23e or 28e-f show dical Exagner must be routiled at	by	3 ☐ Widowed 4 ☐ Divorce	If Yes Give		1 ☐ Yes 2 No	Specify:		Spe	city: Blo	ack	
215-(	ılın 72 h ın "natu Medica	Completed		ent's Education est grade completed)	(Gin	cedent's Usual Occup ve kind of work done o . DO NOT use retired	during most of work	ing	16b. Kind of	Business/In	dustry	
121	filed within Hygiene. other than "		i 2 yr  17. Father's Name (First, Middle		5	aleCler		- (First Minds	Ke	etai	<u> </u>	
lanc	2 should be filed within and Mental Hyglene. is marked other than aumatic event, I to M.	To Be		raven Sr			Bert	e (First, Middle.	CEI	<sub>ame)</sub> Veer	1	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e f show important: If item 27 is marked other than "natural", or items 23e or 28e f show important: If item 23e or 28e f show important items it is marked at 2000.		19a. Informant's Name/Relation	4	10-	iling Address (Street	/ 1 1- 1		City or Tow	vn, State, Zip	Code)	
	es 1 and of Health fitem 27 ir other tra		20a. Method of Disposition	oin (Mother	20b. Place of Dis	position (Name of rematory or other place		ence,	20c. Locatio	n - City or To	own, State	
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 Burial 2 Cremation 4 Donation 5 Other	(Specify)	St Mai	110	. hel	14/2007	Dlan	tas!	C.	
Bal	permit. Departr Importa		21. Signature uneral Service	D. Hackin	A.	Hackett	ss of Facility S Funer	alCh			ur St	
			/	or complications that cause st only one cause on each I	d the death. Do not e line.	A (1		or respiratory arr	est,	1.0	Approximat Interval Bet Onset and I	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or a:	civalicic s a consequence of):	Hrryth	mia				2 hr	
	Examiner	L	Sequentially list conditions,	b. Ca	urdio my	o pathy	ļ				2 year	irs
5	cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.	s a consequence on.						/	
8760,	icate be executed physician and s the burial-transit		resulting in death) Last		s a consequence of):							
9	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	is service	d								
Box	leath certifi attending   I for use as	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B Ectopic pregnancy	,			Date of delive	-	Year
P. O.	t the de by the tached	hysic	1  Yes 2  No 9  Unknown	9□ Unknown	at time of death 5	5 ☐ Other (specify)						
	w requires that the death been signed by the atte should be detached for	b	Part II. Other significant condi	tions contributing to death I	but not resulting in the Heart	underlying cause giv			bacco use co es 2□No		he cause of coably 4 🖼	death? Unknown
Division of Vital Records,	law requas been 2 shoul	Completed		Asthr	ma, O	hesity		24a. Was a		b. Were auto	ppsy findings impletion of c	available
a E	si <b>cian</b> : The law certificate has b rector, page 2 st							perfor		death?	2□ No	3036 01
1 VII		To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 ER/Outpati	ient 3 DOA Oth	er: 4 ☐ Nursing Ho	h (Check only or ome 5 - Resid		Other (Specif	(y)	
o uc	ding After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pend		ury 28b. Time ay Year) Injury	Wor		28d. Describe h				
Visio	Attanding or death. ractor: Atter	Certification:	3 Suicide 6 □ Could	mined 286. Place of In	njury - At home, farm, stc. (Specify)		163 2 140	28f. Location (S City or Tow		mber or Rura	al Route Num	ber,
ā	To the Hospitel or Attending Physical thin 24 hours after death. To the Funaral Diractor: After this cumpletely filled in by the funeral directors.		29a. Certifier 1 <b>▼ Certify</b>	ring Physician: To the best		ath occurred at the time	mo, data and place				totad	
	the Hos in 24 ho the Fun pletely	edical	(Check only 2   Medics	al Examiner: On the basis of and manner si	of examination and/or	investigation, in my o	pinion, death occur	red at the time, o	ause(s) and late and plac	e, and due to	o the cause(s	)
	To the l	Σ	29b. Signature and title of certif	ier	• 0	29c. Licens	6 number 5618	2	9d. Date sig			
	9		30. Name and address of person			e, Print)		1		21-0	/	
			Law Mays and 31. Date filed (Month, Day, Yea		trnum St	NE 311	Wishing	ston DC	. 20	017		
	Sta Registi			2007	is for	de						

Amend 29c, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For Amend #31, perDVR, g867, 5/31/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MECHAN May 200 HNNA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5 Social Security Number **Funeral** Months 1 M 2 XF 216-12-8455 82 6/23/24 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10h County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Baltimore n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 Funeral 102 S. Carrollton Ave. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗷 No Maryland 21215-0036 Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Bakerv 12 marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Catherine Ellen Hall Pages 1 and 2 should I George William Keene မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) s Colleen Karcher / Daughter permit. Pages 1 and. Department of Health Important: If Item 27 any Injury or other troones. 21227 1105 Sulphur Spring Road Baltimore, Maryland 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Glen Haven Mem. Park: 5/22/07 Glen Burnie, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licer 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List priv one cause on each line. Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmanary Chronic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) P.O. Box 68760. physician pe Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ Chronic Moscess 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? 1□ Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27. Manner of Death After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 17,2007 la-clarke M.D. P19839 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. BALAmore, Maryland 21201 Kimberli TAylor-CLARKE M.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

### Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Physician CHESTER 9:10 pm MILKOWSKI MAY 700S 20 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner Brinton Woods Nursing & Rehabilitation Center Svkesville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) August 21 1915 Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 1□M 2□F Days Vrs New York 549 18 6310 Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No **Funeral Director** Baltimore Maryland Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 7840 St Thomas Drive 21236 USA 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 ☐ Yes 2 💆 No Specify: Specify. þ White 3 Widowed 4 Divorced WW II Completed 16b. Kind of Business/Industry 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Letter Carrier US Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Valentine Milkowski Maryanna Glab 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Linda Stanley 2308 Lake Circle Drive Eldersburg, maryland 21784 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 24 2007 4 □ Donation 5 X Other (Specify) Entombment St Stanislaus Mausoleum Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Pert1. Enter the diseese or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (o as a consequence of) Isouratum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 ☐ Pending Naturel 1 Yes investigation

Examiner sician end buriel-transit Hospital or Attending Physician: The law requires thet the death certificate be exacuted Records, P.O. Box 68760. Physician/Medical ð Completed Division of Vital Be ို this Certification:

**Physician** 

/Medical Examiner

**Funeral** 

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, it is Madical Examinar must be notified at

Saltimore, Maryland 21215-0020

To the Hosp...
within 24 hours efter us...
To the Funeral Director: After

edicai State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide rtifyin: ysician: T the sof my know dge soft the occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedicated miner: On expression is of examination of soft investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

2007

6 Could not be determined

3 ☐ Suicide

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Name end eddress of person who completed cause of deeth (tell 23e) (Type, Print) 2 horasthene Sult #20 ·Mru

Jours alun 32. Registrer(s

Registrar **DHMH 16 Rev 6/95** 

			. 101	partment of Health and Mertificate of Death	lental Hygie	4991 10030
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		EILEEN BANKS MILLER		Month 05	19 2007 9pm M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	_xam.		GLEN MEADON	Glen Arm		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	9. Birthplace (State or Foreign Country) 1924 New Jersey
	Director		148-12-4085 <sup>1□M 2</sup> F 83 Yrs.	Months Days Hours Min.	Mar 13,	1924 New Jersey
	DC .		Usual Residence of Decedent			Table Inside City Limite
	arylar show		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 汉 No
	Ba-f	cto	MD Baltimore Glen			
	or 2	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	72 hours after death with the Maryland Insturat', or Items 23a or 28a-f show digal Examiner must be nutified at		11630 Glen Arm Road	21057		
	er de Items	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
36	s aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 № No Specify:		Specify: White
8	"natural",		^	cedent's Usual Occupation	161	b. Kind of Business/Industry
15	C	Completed	(Specify only highest grade completed) (G	ve kind of work done during most of work . DO NOT use retired)	ing	
212	within jiene. r than "	E	Elementary/Secondary (0-12) College (1-4or 5+)	cretary	Me	edical/ Education
b	be filed withi tal Hygiene. d other than event, Ire M	a l	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	iden Sumame)
Maryland 21215-0036		To B	Thomas Banks	Viole	et	Hastie
ar	and and sum			iling Address (Street and Number or Rura		
	1 and 2 Health tem 27 l		3	3 Valewood Rd., Tou		21286
ore	100			rematory or other place)		c. Location - City or Town, State
<u>Ĕ</u>	Pages ment of I ant: If its ury or o		'4 □Donation 5 □Other (Specify)   Highvieu	Mem'l Gard   5/2	+/07 F:	allston, MD
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee Hilliam G. Dau	22. Name and Address of Facility Ruo 1050 York Rd., Tows		Funeral Home, Inc. 21204
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition 14472R (	AR NIA		Onset and Death
	/Medical				000	1210 0 =
	Examiner		Sequentially list conditions b. DIAPAGR	HMM H-I)C	17/4/14	LYSIS 3 years SEMYELNATING
	σ \ / =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1 1 20	ENVENTERNE
	xecuted and	Examine	Cause (Disease or injury that initiated events	MINIUNIEMEDI	HILDI	The It of Bollow
90,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	POLYNE	-012-0	F F F F 7 0 420
8760	physician and the burial-transit	Physician/Medical	d			3 412 113
9	entific ling p	Mec	IF FEMALE:			
Вох	leath certifica attending ph I for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	B ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
0.	at the dea by the a tached fa	/sic	1 Yes 27 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		
Θ.	that the seed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobac	cco use contribute to the cause of death?
ds,	96	l by	DIABETEC MEL	LITUS	1 ☐ Yes	2 ≥No 3 Probably 4 Unknown
Vital Records,	w require been si should b	ompieted	HILARO TRAICAN			
360	e law has l	npi	19 12 12 103 ( UI		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
		0				INo 1 ☐ Yes 2 ☐ No
Vit	ysician: Th	Be	25. Was case referred to medical examiner?  Hospital:	au distin	(Check only one)	
of	d = le	2	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time	ient 3 DOA 4 Nursing Ho	me 5 🗌 Residenc 28d. Describe how	ce 6 Other (Specify)
on	ding h. After fune	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injur		Edd. Doddibo Now	inquiy occurred
:3	deat deat ctor: y the	fica	3 Suicide 6 Could not be 280 Blace of Injury - At home form		28f. Location (Stree	at and Number or Rural Route Number,
Division	spital or Attending I ours after death. heral Director: After filled in by the funer	Certification;	4 Homicide determined 200. Flace of flight? Actionis, fam, building, etc. (Specify)	,	City or Town, S	State)
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 121 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place.	and due to the caus	se(s) and manner as stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) Redical Examiner: On the basis of examination and/or and manner stated.			
	vithin Fo th	Me	29b Signature and title of certifier D	29c. License number	29d.	. Date signed (Month, Day, Year)
			L'horactor at	DS1228	0.	5/20/07
	12		30. Name and address of pergon who completed cause of death (Item 27a) (Tay	e, Prior R RALLING	(2.000	1 m #154
	1 0		RAMANA GOPALAN MI	2/2 KOLLING	(2005 RO	AD #157 BACTIMORE 21228
	Sta	ite	37. Date filed (Month, Day, Year) 32. Registrar's Signature	**		
	Registi	ar	MAY 2 3 2007 Aser &			

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** РМ MAY IDA MASHBAUM 20 2007 4:18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NORTH OAKS HEALTH CENTER PIKESVILLE 8. Date of Birth (Month, Day, Year) 10/18/1906 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Min. 108-10-6251 Director 100 UKRAINE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Director MD BALTIMORE BAI TIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 725 MT. WILSON LANE, #34 21208 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOUSEWIFE** OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHANUCK HANDELMAN **GERTRUDE** ပ **JACOB** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 OAKTON COURT, BALTIMORE, MD JESSE MASHBAUM / SON injury or other 20b. Place of Disposition (Name of HEBREW YOUNG MENS 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/21/2007 | BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or, Examine burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 → Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 1□ Yes 12□ No To the Hospital or Attending Physician: ours after death.

Interest of the servific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Other: 1 Yes 2 No 1 | Inpatient ဥ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Fun and manner stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 28591 Melli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 AVE, SUITE BARD MIN 21209 2835 1 ASNEDM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 Registra DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Registrar

State

1130

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

MD

36. Registrar's Signature

VAYWIZA

MAY 2 3 2007

31. Date filed (Month, Day, Year)

Baltmore Blue westminster. MD 21157

	0.00	For State Registrer	State of Maryla	,	artment of F			ene g. No.2 0 0 7	16693
Physici /Medi		Decedent's Name (First, Middle, Las Clarence	B. Panr	nell			2. Date of Death	Day 2007 ear	3. Time of Death 5:25 p
Examir	er	4a. Facility Name (If not institution, give Future Care Pi	neview		Clinto			4c. County of Death	
Funeral Director		5. Social Security Number 223-40-6321 6. Social Security Number 1	7. Age (In yr ▼MM 2□ F	2 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, ) 0 2 - 1 6 - 1	935 Virg	place (State or Foreigntry) Tinia
Maryland -f show fied at	tor	10a. State 10b. County	PG 10c. (	City, Town or Lo	Clir	nton			10d. Inside City Limits
h with the 3a or 28a	ai Director	10e. Street and Number 9106 Pineview	Lane		10f. Zip Code	20735	10	g. Citizen of What Cou USA	ntry?
d within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Avedical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  Y☐ Yes 2☐ No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
within iene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired Carrier	during most of wor	rking	6b. Kind of Business/In DC Govern	,
permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event. In 2008.	To Be C	17. Father's Name (First, Middle, Last)	nknown			18. Mother's Nar Bessie	ne (First, Middle, Ma Maud	Pannell	
ind 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (7 Bethann Thomas/		19b. Mailii 3414	ng Address (Street Curtis	ond Number or Ru Dr. #20	oral Route Number, 0 08 Suitl	City or Town, State, Zipand, MD 20	7 4 6
Pages 1 a nent of He int: If Item iry or othi		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	incoln	matory or other place Memoria	1   5-2	I-07 S	oc. Location - City or To uitland,	MD
permit. Departn Imports any Inju		21. Signature of Funeral Servi a D	andor				The state of the s	lor II FF more, MD	
Medical Examiner be executed by sician and bhysician and stree burial-transit	edicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  b. Due to (or as a cons  c. Due to (or as a cons  d	equence of):		7 7 7 7		LAR DIS	
ath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of deliving Month	ery Day Year
that ed b deta	ρ	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.		cco use contribute to t	he cause of death?
: The law requires cete has been sign page 2 should be	Completed						24a. Was an autopsy performe	ed? prior to co	opsy findings availat impletion of cause of 2 No
Attending Physician: 1 r death. sctor: After this certificel by the funeral director, p	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier  28b. Time o	f 28c, Injur	er: Nursing H	ath (Check only one) lome 5 Residen 28d. Describe how	ce 6 Other (Special	<b>(y</b> )
교육등	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe		reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
the Hospital hin 24 hours a the Funeral I holetely filled	edicai	one) 2 Medical Exam	ysician: To the best of my k liner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	vestigation, in my o	pinion, death occu	irred at the time, dat	e and place, and due t	o the cause(s)
To the I	Σ	29b. Signature and title of certifier		m	29c. Licens	1854	5 1	d. Date signed (Month,	7 780
0,		30 Name and address of person who	1 M.D. 17	2070	Print)	NE CE	NFOL U	DACDONF,	Ad. Za
Sta Regist	_	31. Date filed (Month, Day, Year)  MAY 2. 3 200	7 Registrar's Sig	gnature de	A.D			(	

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No made	100	E. Carlo	1	1	0	V	-

State of Maryland / Department of Health and Mental Hygiene Matthew John Payne Certificate of Death Reg. No 1- For State 3. Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day May 18, 2007 2333 hrs ysician/ JOHN TTHEW ≟xaminer Mec 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and numbe **Baltimore County** Woodstock Old Court Road/ Davis Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Country) NH 5. Social Security Number **Funeral** Months Days Hours 28 Director 1 X M 2 F 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State any 1 Yes 2 No WESTMINSTER 10f. Zip Code CARROLL or items 23a or 28a-f show must be notified at once. 10g. Citizen of What Country? filed within 72 hours after death with the Maryland Director 10e. Street and Number () SA COON CLUB ROAD 2332 14, Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Funeral 11. Marital Status Armed Forces? 1 Never Married 2 Married Specify: WHITE Yes 1 Yes 2 No specify: Yes. Give Year Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Examiner 15. Decedent's Education (Specify only highest grade completed) HARLEY-DAVIDSON during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) narked other than " WRITER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H. Important: If item 27 is marked o injury or other traumatic event, the Be 2121 COONCLUBROAD WESTMINSTERMO 21157 9 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 5/24/2007 HAMPSTEAD, MD crematory or other place) Baltimore, Burial 2 Cremation 3 Removal from State CAPROLL CREMATION INC Donation 5 Other Specify 21. Signature of Funeral Service Licensee SYKESVILLEROAD ELDERS BURGING 21784 sumbrun 23a. Part UEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and /sician failure. List only one cause on each line. /Medical Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED e attending physician a for use as the burial -UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year IF FEMALE Day Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the signed by the attending be detached for use as 1 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown O ģ 24b. Were autopsy findings available 24a. Was an Completed of Vital Records, ficate has been si, page 2 should b prior to completion of cause of autopsy death? performed? 1 V Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) director, 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene examiner? ER/Outpatient 3 DOA Inpatient 2 this ٩ 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Yeer) FOUND: 28b. Time of Injury funeral Driver in motor vehicle accident 27. Manner of Death Certification: FOUND: 1 Yes 2 ✔ No 1 Natural within 24 hours after death.

To the Funeral Director: A Pending Division May 18, 2007 2324 hrs 28f. Location (Street and Number or Rural Route Number, City Investigation 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State)
Old Court Road/Davis Avenue, Woodstock, Md. Could not be 3 Suicide (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Check only 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title of certifier May 19, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2

			State of Maryland / Department of Health and N 1- State Amend #5, perFH, g867, 5/23/07 TT Certificate of Death	lental Hyg	liene	
				R	leg. No. 2007	16695
	Physici		1. Decedent's Name (First, Middle, Last)  RD hozi F E Parker	2. Date of Dea	th Day Year	3. Time of Death  M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	05	4c. County of Death	
			Glen Burne Health and Rehab Glen Burnie		AA	
L	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day)	(Year) Co	place (State or Foreign intry) v1and
	yland yland		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location			10d. Inside City Limits
	se-fst	Director	Maryland N/A Baltimore			1 XYes 2 No
	in 72 hours after death with the Maryland "natural", or Items 236 or 28e-f show Walcal Extropret must be notified at		106. Street and Number 1328 Sargeant Street 2	1223	I0g. Citizen of What Co USA	intry?
٥	after des or items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  11 □ Yes 2 ☒ No	ecify Yes or No- Rican, etc.)		
-0036	2 hours after atural, or ite	ted by	Year or Dates:  15. Decedent's Education  16a. Decedent's Usual Occupation		Specify: 16b. Kind of Business/I	White
213	within 72 ene. than "nai	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	ing	Self-emple	, mod
2	be filed w tal Hygier d other tl avant, ID	e Col	6 0 Body & Fender Man  17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, i		by ed
ylan		To B	Lloyd Parker Marion	Kaler		
Mar	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		Roxane L. Parker (Daughter)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run 1328 Sargeant St., Ba		•	ip Code) 21223
J.e	es 1 ar of Hea if itam or other	-			20c. Location - City or	
			`4 □Donation 5 □Other (Specify) Bayview Crematory, Inc. 5/2	23/07	Baltimore,	Maryland
Balt	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee Kevin E Ecker  McCully-Polyniak Fr 237 E. Patapsco Ave	uneral H	lome, P.A.	225-1856
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical	П	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ARI	CEST	Onset and Death
	Examiner		Due to (or as a consequence of):	2/2/1/	6	
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
S S	be executed sician and burial-transit		that initiated events resulting in death) Last  C. Due to (or as a consequence of):			
09/89	m × m	dlcal	a Liver Animpe			
ZOZ	h certifica ending ph	ın/Me	IF FEMALE:  23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	,
р Э	the death by the atten ached for u	Physiclan/Med	in the past 12 months?  1   Yes 2   No 9   Unknown		Month	Day Year
N.	vician: The law requires that the death certifica certificate has been signed by the attending ph rector, page 2 should be detached for use as th	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribute to	
ecoras	law req as beer 2 shou	Completed	G-I-BUETHING - ANDMIA	24a. Was a		opsy findings available
r	: The cate ha	Com		perforr	ned? death? 2 √No 1 ☐ Yes	212 No
VIII	yaician: is certific director,	o Be	25. Was case referred to medical examiner?  1		e) ence 6 Other (Spec	24.1
10 UC	To the Hospital or Attending Physician: within 24 hours after deals. To the Funarel Director: After this certific completely filled in by the funeral director,	-	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?		ow injury occurred	
UNISION	Attender ractor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined letermined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or Ru	al Route Number,
5	pftal or					
	ne Hos n 24 ho he Fun	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To t Withi To tl	2	29b. Signature and title of cariffier / 12 / 29c. License number		9d. Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CAPLOS PHILING HUG M.D. 4115 PITCHIL	1/2	11419-	2017
	3			E HIDY	ISBLTO 1.	VILI aldas
	Sta Registr		31. Date filed (Month, Day, Year) S2. Registrar's Signature			

			1 - For State Registrar	State of Ma		epartment Certificate				iene 007	15696
9	Physici /Medi		1. Decedent's Name (First, Middle, Howard	Cepha.	s Pre	zsber		Sr.	2. Date of Deat Month	Day Year 17 200	7 600 PM
	Examir	ier	4a. Facility Name (If not institution, BOLTINGTE VA	nedical Ce		B	( ( )	Mor		4c. County of De	
	Funeral Director		5. Social Security Number  197-24-2205  Usual Residence of Decedent	5. Sex 7. Age 1000 7. Age	(In yrs. last birth	Months	Days Hours	ler 24 Hrs. s Min.	8. Date of Birth (Month, Day, MARCH 2	Year) 9. B 1 1930 1	irthplace (State or Foreign Sountry) MARYLAND
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow ta Marical Exacili at naual be notified at	Director	10a. State 10b. County	ORD CO	10c. City, Town	or Location RLINGTO	N				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ath with the 23s or 2 could be man	rai Dire	10e. Street and Number 2235 GLEN COVE	RD		10f. Zip (	Code 21034		1	0g. Citizen of What C	Country?
036	urs after de al', or Itema	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? d tx⊠res 2 □ No If Yes, Give Year or Dates:		13. Was Decede if Yes, speci 1 ☐ Yes 2			ify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify: BI	ite, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23a or 28a-f ehow appring to other treumatic event, the Medical Exaction and the notified at ance.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)		ecedent's Usual Give kind of work fe. DO NOT use	c done durina m	ost of workin	g	16b. Kind of Busines	
and 2	buld be filed w Mental Hygier arked other ti atto event, to	Be	12 Yrs  17. Father's Name (First, Middle, La		M	EDICAL 1				VETERANS Maiden Surname)	
	and 2 should leath and Men n 27 is marke	To	WILLIAM M PRESB  19a. Informant's Name/Relationship	(Type, Print)				ber or Rural	Route Number,	E PRESBERI	Zip Code)
altimore,	Pages 1 and 3 nent of Health int: If Item 27 iry or other tre		Doris T. Presbe  20a. Method of Disposition  AZBurial 2 □ Cremation 3  4 □ Dongation 5 □ Other (Spe	☐Removal from State	20b. Place of D cemetery,	isposition (Name crematory or other) Y CEMETI	e of ner place)	05-25-	ite 2	n, Marylar 20c. Location - City o	
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Fundiral Service L	4	DERREE	22 Name and WILLIAN	Address of Fac 1 C BROV	NY COM	M FUNERA		ARFORD, P.A.
	Physician		233. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	implications that caused the ly one cause on each line							Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	b. 605+1	consequence of)						5yrs
(4)	rate be executed hysician and the burial-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· demen	consequence of)  Consequence of)						loyre
68760,	death certificate be executed e attending physician and nd for use as the burial-transit	Medical	IF FEMALE:	d							
P.O. Box	the death certific y the attending p ached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetel death	3 Ectopic pre- 5 Other (spe-				23d. Date of de Month	olivery Day Year
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		Completed							24a. Was ar autopsy perform 124 Yes 2	prior to death?	utopsy findings available completion of cause of s
	Physicial this certil al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No	Hospital:	2 🗆 ER/Outpa	itient 3 DOA	1 04		Check only one 5 Resider	nce 6 ☐Other (Spe	əcify)
Division of	After After Tune	ertification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Y	/ear) 28b. Tim Inju	e of 28	c. Injury at Work? 1 □ Yes 2[	28		w injury occurred	
	spital or Attend ours after death neral Director: filled in by the f	O	4 Homicide determine	building, etc.	(Specity)				City or Town,		
	5 4 7 9	Medicai	29a. Certifier Certifyin 2 Medical Ex	Physician: To the best of aminer: On the basis of each manner state	xamination and/o	anth occurred at r investigation, i	the time, date to n my opinion, de	and place, an eath occurred	d dus to the est fat the time, da	te and place, and du	s stated. e to the cause(s)
ł	To the Within 2 To the complet	×	29b. Signature and title of certifier	1,D.		1	License number (176435)			d. Date signed (Mon	
ĺ	,+1		30. Name and address of person who SIK HUR	o completed cause of dea	th (Item 23a) (Ty	pe, Print) ene 5-	treet	Balt	more	MD ZI	201
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's		Coole					

			1 - For State Registrar	State of Mai		rtificate of L		ental Hyglei Reg.	F 0 0 1	16691
	Physic	an	1. Decedent's Name (First, Middle, La	-				2. Date of Death Month	Day Year	3. Time of Death
1	/Medi		Rosalee		ırley	Rathe		5 18	2007	3:35p M
٨	Examir	ner	4a. Facility Name (If not institution, given 2628 Cecil A			4b. City, Town, or Bal	Location of Death timore		4c. County of Death NA	
	Funeral Director			Sex 7. Age 11 M 2 K 63	(In yrs. last birthday) Yrs.	It Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Ye 6-1-19		place (State or Foreign ntry)  Md.
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  NA		10c. City, Town or Lo	cation Ltimore				10d. toside City Limits 1 ☐ Yes 2 ☐ No
	With the	al Direc	10e. Street and Number 2628 Cecil Av	zenue		10f. Zip Code 2	1218	10g.	Citizen of What Cou USA	ntry?
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelth and Mental Hygiene. If Item 27 is marked other then "naturel", or Items 23s or 28s-f show or other traumatic event, to Medical Examinar must be recitified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His t Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:	
5-0	72 hc	eted	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Dece	dent's Usual Occupa kind of work done di	tion uring most of working	16b	. Kind of Business/In	dustry
121	within	Completed	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+)		oo NOT use retired) sekeepir			ood Sama	ritan
	Hygie Hygie ther	ပိ	17. Father's Name (First, Middle, Last	)	IIO U		18. Mother's Name			LILAII
Maryland	s 1 and 2 should be filed within if Heelth and Mental Hygiene. Item 27 is marked other then other traumatic event, tra Ms	To Be	Ross	В	arnett			sie	Jone	S
ary	should be man	_	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Rural	Route Number, Cit	y or Town, State, Zip	Code)
	and 2 selth a n 27 i		Douglas Jerom	e Rather	Husband	2628	Cecil A	ve., Bai	ltimore,	Md. 2121
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth	1000	20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		20b. Place of Dispo cemetery, crer King M	sition (Name of natory or other place em. Pk.	5-24·		Location - City or To Randall	stown, Md
Balt	permit. Page Department o Important: If eny injury or once.		21. Signature on Funeral Service Lice	nsee		Name and Address	I.	larch F.	H. East timore,	Md. 21202
o, ≪	Physician pe executed of bhysician at the burial-transit	fedical Examiner	23a. Part 1. Enter the disease, or comshock, or heart tailure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a continue).	consequence ot):	Circ				Interval Between, Onset and Death
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O. Box	The law requires that the death certific tte has been signed by the atlanding p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2   4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, P	w requires thet been signed t should be deta	þ	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause giver	n in Part I.		o use contribute to the	ne cause of death?
al Records,		Completed						24a. Was an autopsy performed 1 Yes 2 1	prior to con death?	psy tindings available mpletion of cause ot
Vital		o Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death			
ō	g Physical dispersion	-	1 ☐ Yes 2 No	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y		28c. Injury	4   Nursing Home	d. Describe how in	6 Other (Specify	y)
ion	별목절	atio	2 Accident 5 Pending investigation		(ea <i>r</i> ) Intury		es 2 No		()	
Division		Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of triury building, etc. (	- At home, tarm, str (Specify)	eet, tactory, office	28	t. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir cumpletely filled in	edicai	29a. Certifier (Check only one) 2 Medical Exam	eysician: To the best of r niner: On the basis of ex and manner state	camination and/or inv	occurred at the time restigation, in my opi	date and place an nion, death occurred	d due to the nause at the time, date a	(s) and marrier as all and place, and due to	ated the cause(s)
	To the vithin 2 To the cumplet	¥	29b. Signature and title of certifier			29c. License	number	29d. [	Date signed (Month,	2 7
	3		30. Name and address of person woo	completed cause of deal	th (Item 23a) (Type,	Print)	11	14.	1 00	2007
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	ET 100	Timoli	May	(F) 9 U	X1218
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			1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			1	Reg. No.	07	16698
	Physici	an	Decedent's Name (First, Middle, Last,	)					2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medi		Dorothy Elizabeth		d	1			May	17, 200		6" AM
7	Examir	ner	4a. Facility Name (If not institution, give					tion of Death			ty of Death	
			Brightview Assist 5. Social Security Number 6. Sec		s. last birthday)	If Under 1	atons	VILLE	8. Date of Birt		1t imc	
п	Funeral Director			M 2/2 F	97 Yrs.		Days Ho		5/30/0	y, Year)		place (State or Foreign ntry) ISYlvania
			Usual Residence of Decedent		91	1			10010	J J	I CIII	sylvania
	72 hours after death with the Maryland natural; or itsma 23a or 28a-f show disal Examinar must be modified at		10a. State 10b. County	10c. (	City, Town or Lo	ocation						10d. Inside City Limits
	Ma S-1-8	ctor	Md Baltim	ore	Cato	nsvill	.e					1 ☐ Yes 2157No
	다 다 6.28	Funeral Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen of	What Cou	ntry?
	23a	ral	6610 Rannoch Driv				21228				USA	
	ts ms	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder If Yes, specify	nt of Hispani y Cuban, <mark>M</mark> e	ic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ace - Ameri ack, White,	can Indian, etc.
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 25	No Spe	ecify:		Spec	ify:	71 • .
21215-0036	hour turs!	pe pe	15. Decedent's Edu		163 Doco	dent's Usual (	Occupation			16b. Kind of		hite
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	Hygi other	0	17. Father's Name (First, Middle, Last)		<u> </u>	nouco.		Mother's Nam	e (First, Middle,	Maiden Suma		
an	lid be lental ked c	To B	Edward Augustus G	otlieb Herma	nn			Emma 1	Butz1er			
Maryland	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the Me	-	19a. Informant's Name/Relationship (T)	* "		ng Address (	Street and N	lumber or Run	al Route Numbe	er, City or Town	n, State, Zi	p Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelih and Mental Hygiene. If Itsm 27 is marked other then "natural", or itsms 23a or 28a-f show to other traumatic event, the Medical Examinar must be notified at		Mr. Steve Reid /	Son	10 N.	Beaum	ont A	ve. Ca	tonsvil	le. Mar	vland	21228
Baltimore,	ges 1 and 2 it of Heelth If Itsm 27 or other tra		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ F		. Place of Dispo cemetery, cre	sition (Name	of		Date	20c. Location		
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a	permit. Departr Importa sny Inju		21. Signature of Funeral Service Licens			2. Name and			oudon P			
<u>m</u>	g ⊊ ≅ g		Cugene V.	Cart	3	620 Wi	1kens	Ave.	Baltimo:	re, Mar	yland	21229
1			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the de	ath. Do not en	ter the mode	of dying, suc	ch as cardiac	or respiratory a	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	.0.	1		el l	_		
н	Lxammer	_	Sequentially list conditions,	. Pothers	rusa	Co	no	11000	15	Offer	1	
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or as a cons	equence or):							
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Вох	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg						23d. D	ate of deliv	erv
B	death a atte	ciai	in the past 12 months? 1 □ Yes 2 ♥ No	1 Live birth 2 ☐ Fe 4 Pregnant at time o		⊒Ectopic preg ⊒ Other (spec				1	lonth	Day Year
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	The law requires that the ste has been signed by th bage 2 should be detache	y P	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cau	ıse given in f	Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?
Records,	an sig	P P	FR. lene to The	nive			·		10	res 25 No	3 ☐ Pro	bably 4 □Unknown
၀	s bee	piet							24a. Was		. Were aut	opsy findings available
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>	lysicl lis ce direc	To B	examiner? 1 ☐ Yes 2 ⑤ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA	Other: 4[	Nursing Ho	me 5 Resi	dence 6 □O	ther (Speci	fy)
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Ö	ath. or: Af	atic	2 ☐ Accident investigation			М	1 🗌 Yes	2 □No				
Division	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory,	office		28f. Location (S City or Tox		ber or Rur	al Route Number,
D	To the Hospital or Attanding Physician: The law requir within 24 hours effected.  To the Funers! Director: After this certificate has been si completely filled in by the funeral director, page 2 should											
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	thin 2 the mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.			License num			29d. Date sign		
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	Regist		MAY 2 3 200	1 Blances A	T ASSESSED	- Edward						

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 05 08:21 AM<sup>M</sup> 2007 John F. Rambol 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Bel Air, Maryland Under 1 Year | If Under 24 Hrs. | 8. 8. Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. 1**∑**M 2□ F Maryland 216-52-2306 60 08/05/1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Harford Fallston MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21047 2407 Burnham Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Industry Systems Consultant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha E. Mulnaur Francis Rambol 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Burnham Drive - Fallston, Maryland W. Roberta Rambol (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 05/19/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NTRACRANEAC disease or condition resulting in death) Due to (or as a consequence of) hours pertensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27 Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

Director

Funeral

2

Completed

Be 2

sho Id be filed within 72 hours after death with the Maryland of hental Hygene.
marked other than "natural", or items 23a or 28a-f show

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Pages 1 permit. Pages Department of Important: If It any Injury or o

Baltimore,

signed by the d

Physician/Medical

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Completed

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Certification:

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

determined

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica vers after death.

or Vital Récords.

State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

M.D. 500 Upper Chesapeake Medical Dr. Bel Air, MD 21014

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 State of Maryland / Department of Health and Mental Hygiene per dr., g507,05/23/0/dbb ficate of Death

Reg. No. Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13<sup>Day</sup> 200<sup>Y</sup>7<sup>ar</sup> MAOnth **Physician** Domenic Romeo Unknown М /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 328 South Woodward Drive Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours **¼** M 2∏ F Italy 274-26-8801 75 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21221 328 South Woodward Drive Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**X** No White Specify: Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Ship Fitter 12th traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be MArie unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4812 Mandan Road Virginia Beach VA 23462 Mary L. Knighten /daughter nt of Health a Injury or other Baltimore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 5/19/07 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD Department of Important: If any Injury or once. 4 ☐ Donation 5 Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death CARCINOMA Immediate Cause (Final **Physician** Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 OBSTRUCTIVE CHRONIC 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perfor certificate Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No
27. Manner of Peath Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

MD, ESSEX MED CENTER, 404 Eastern Blud 21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

GAUHAR

			For State of Mar State of Mar Registrar		artment of He rtificate of D			jiene leg. No 200	7 16	701
	Physici		1. Decedent's Name (First, Middle, Last)  William R. Rible	++			2. Date of Dea Month May 1	_ Day	Year	of Death
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)	- L	4b. City, Town, or	Location of Death		4c. County o	12:40 of Death	U P
1			419 Russell Avenue #109			ersburg		Mont	gomery	
do	Funeral Director		369-14-4680 <sup>1X) M 2□ F</sup>	(In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day)	1920	9. Birthplace (State Country) Indiana	
	and w		Usual Residence of Decedent           10a. State         10b. County         1	0c. City, Town or Loc	cation				10d. Inside	City Limits
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	or 28;	Director	10e. Street and Number		10f. Zip Code		1	I0g. Citizen of WI	nat Country?	
	s 23a nust t		419 Russell Avenue #109	or in 116 12 1	20877			United S	tates - American Indian,	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☆ Wildowed 4 □ Divorced  12. Was Decedent Even Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates 92	I .	Was Decedent of His f Yes, specify Cubar I □ Yes 2 <b>欠</b> No	spanic Ongin? (S) n, Mexican, Puerto Specity:	o Rican, etc.)		White	
5-0	72 ho "natur dical	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done di DO NOT use retired)	ition uring most of wor	king	16b. Kind of Bus	iness/Industry	
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d 2	e filed al Hygi other vent, tl	Be C	17. Father's Name (First, Middle, Last)	nave			ne (First, Middle,			
ylar	should be ind Mental ind Mental ind Mental individual i	ToE	Victor Bryan Riblett, Sr.	1			Ritter			
, Maryland 21215-0036	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (Type. Print) William Richard Riblett, Jr 🗸 S	Son   2430 :	g Address <i>(Street al</i> South Lynr	Street,				2202
altimore,	Pages 1 nent of Hk ant: If Iten ary or oth		20a. Method of Disposition  1  ☐ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	Arlington Cemetery crem	sition (Name of natory of other place National Prv	<sup>y</sup> Augu: 200	st 3,		oity or Town, State  Note: Town, State  Note: Town, State	ia
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	R22	Name and Address Dert A. F O West Mor	of Facility umphrey	Funeral	Home/Ro	ckville,	Inc.
	<b>%</b>		23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arr	est,	Approxim Interval B	nate Between
1	Physician			nson's Dis	sease				Onset and 10 years	
	/Medical Examiner		Due to (or as a c	consequence of):						
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):						
	ecutec and transi	Examiner	that mulated events c.							
68760,	ficate be executed physician and sthe burial-transit		Due to (or as a d	onsequence or):						
687	ificate g phys	edical	d							
Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf 1 □ Live birth 2 □ 4 □ Pregnant at tim	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day	Year
ds, P.0	ss tha	þ	Part II. Other significant conditions contributing to death but or Chronic Lymphatic Leukemia	not resulting in the un	nderlying cause give	n in Part I.			oute to the cause of	
COL	> Q S	etec					24a. Was a		ere autopsy finding	
or Vital Records,	The la ate has page 2	Completed					autops	med? pr	ior to completion of eath?	
Ζ		Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ★No  Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	Othor		th (Check only or			
ا ور	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of			ome 5 Residence 28d. Describe he	ow injury occurre		
sior	Attending Fr death. ector: After	atio	2 Accident investigation	(ear) Injury		es 2 □ No				
Division	tal or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (	- At home, farm, stre (Specify)	eet, factory, office		28f. Location (Si City or Town		r or Rural Route Nu	ımber,
	To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of reading the basis of examiner: On the basis of examiner and manner state.	xamination and/or inv	n occurred at the time vestigation, in my op	e, date and place pinion, death occu	, and due to the corred at the time, o	ause(s) and man date and place, a	ner as stated. nd due to the cause	9(S)
	To t	Ž	29b. Signature and title of certifier	4 57	29c. License	number	2	29d. Date signed	(Month, Day, Year)	
			Kund Dollen	100	D09	577		May 18,	2007	
	15×1			connection	ut Avenue	#606 <b>,</b> 1	Kensingt	on, Mary	land 2089	95
	Sta Begistr	_	31. Date filed (Month, Day, Year)  32. Registrar's	, cignatule	all of					

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death y 17,2007 Physician 9:20P M Ronnie Angel Robinson May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. 13, 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 5 T MD 219.56.7459 55 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10a. State 10b. County Milford 1 ☐ Yes 2 No DE Sussex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 19963 9191 Shore Drive or items 23a Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2€ No Specify Specify: \$ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Sales the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Grace C. Matthew Paul W. Angel, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 9191 Shore Drive Milford, DE 19963 John E. Robinson/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 05.19.07 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD M01443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ovazian **Physician** Cancer 12WS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2: autopsy perform 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 No Stother (Specify) WOSP Lil 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this To the Hospital or Attending Ph within 24 hours all er death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Æ Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007

State Registrar

31. Date filed (Month, Day, Year)

MAY 2 3 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2 Registrar's Signature

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leve ST TOWSON MO 21202

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** DENA RAITZYK MAY 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs HOSPICE OF BALTIMORE GILCHRIST CTR BALTIMORE 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Funeral Days 219-70-9617 1 □ M 2 X F 46 0973071960 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a, State 28a-f show at r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1 ☐Yes 2 ☐ No MD BALTIMORE Director RANDALLSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4265 MARY RIDGE DRIVE 21133 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced þ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 l (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) GRAPHIC DESIGN DESIGN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH LOVE JANET ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JACKIE SHUMAN / AUNT 11905 RIDGE VALLEY DRIVE-OWINGS MILLS, MD 21117 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) OHE RETHINGS RAFL 22. Name and Address of Facility 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/21/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Month Leuns 8900 REISTERSTOWN ROAD - PIKESVILLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mes Cance WS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the party inder an Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 211 No page 2 s 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) No. 3914 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To nours after death. neral Director: After this filled in by the funeral d 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 NONatural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles Sr powsed MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Deçedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 12:190. RMAN 0200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL CENTOR SALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F 9 217-10-835 MD Director 01-17-1916 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2323 N. Ashburton Street 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status 'natural', or iter dical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No African-Specify. þ 3 ☐ Widowed 4 ☐ Divorced American Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Steel Steel Worker 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Stafford Gracie Mae Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type. Print) of Health a Louise Stafford/ wife <u>2323 N. Ashburton Street, Balto. MD</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 New jal 2 ☐ Cremation 3 ☐ Removal from § Woodlawn Cem. 5-25-07 Woodlawn, MD 4 Donation 5 ☐ Other (Specify) of Funeral Service License Wylie F/H P.A. of Balto. Co Meda Rd., Randallstown, Liberty MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed anding physician and use as the burial-transi or Vital Records, P.O. Box 68760, Cy Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed?∕ 1☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s 1 □ Yes 2 No Hospital or Attending Physician: 24 hours after death.

Puneral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 201No Other: P 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

Mysician

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician 10:00 PM May 18 2007 Christine Schulte Maxine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. B. Date of Birth (Month, Day, Year)
December 29 1918

9. Birthplace (State or Foreign Country)
Baltimore, Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 216 03 3045 88 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 7550 Belair Road 21236 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: þ Specify 3 ☐ Widowed 4 € Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collection Officer Spiegel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maxmillian Reiner Roehre Unknown Punte 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven R Schulte 8005 Yellowstone Road Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St Peter Luth. Ch Cem. May 22 2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) e of Funeral Service Lidensee 22. Name and Address of Facility Lassahn Funeral Home Inc Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory alrest, solicity of the control of the con Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) rany leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 4 Pregnant at time of death 9 Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ▼ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 X Other (Specify) HOSPICE nours after death.

neral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 2 3 2007

Baltimore, Maryland 21215-0036

or Vital Records, P.O. Box 68760

			1- For State of Maryland / Dep Ce	artment of Health and N rtificate of Death	, ,	iene eg. No. 2 () () 7	16706
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th 21 <sup>Day</sup> 2007	3. Time of Death
	/Medi Examir		Margaret E. Steffan  4a. Facility Name (If not institution, give street and number)  Multi-Medical Center	4b. City, Town, or Location of Death Towson	May	4c. County of Death Baltimo:	2:00 A M
\(\frac{1}{2}\)	Funeral Director		5. Social Security Number 241-14-1508 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 85 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Aug 17,	9. Birth 1921 Vire	place (State or Foreign ntry) ginia
	Maryland -f show fled at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  MD Baltimore Esse				10d. Inside City Limits 1 ☐ Yes 2 \( \bigcirc \) No
	th with the 23a or 28a 1st be noti	al Director	10e. Street and Number 9 Beefwood Court	10f. Zip Code 21221	1	0g. Citizen of What Cou USA	ntry?
036	be filed within 72 hours after death with the Maryland ttal Hyglene, ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be norifled at	by Funeral	11. Marital Status  1 Marital	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.
9500-51212	d within 72 ho giene, r than "natu the Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)  maker	ing	own home	dustry
yland	ould be filed wental Hygid Mental Hygid arked other atic event, th	To Be C	17. Father's Name (First, Middle, Last) Louis F. Steffan	18. Mother's Nam	e (First, Middle, M ian M.	,	
e, mar	is 1 and 2 sho of Health and Item 27 is m.		Stephanie Kvech /daughter 9 B	ng Address (Street and Number or Rur eefwood Court E	Baltimo	re MD 212:	21
saitimore,	permit, Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic even once.		4 Donation 5 Dottler (Specify)	d Cemetery 5/24	./07	20c. Location - City or To Baltimore	MD
g	Depril Impo		What to population	Connelly Funera	1_Home		
<u>د</u>	Physician // Medical Examiner and the prujetrausit the prujetrausit in the prujetrausi	Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Dementie			Interval Between Onset and Death
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r	n: The law r ficate has be r, page 2 sh	Completed			24a. Was ar autops perform 1∐ Yes 2	y prior to co ned? death?	psy findings available mpletion of cause of 2 No
	g Physicia er this certi eral directo	л: То Ве	25. Was case referred to medical examiner?  1		me 5□Reside	nce 6 □Other (Specifi w injury occurred	y)
DIVISION	of the Hospital or Attending Physician: with 24 hours after death of the Funeral Director; After this certifica completely filled in by the funeral director,	Certification:	Matural 5 □ Pending (Month, Ďay Year) Injury 2 □ Accident investigation 3 □ Suícide 6 □ Could not be determined 28e. Place of injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town	reet and Number or Rura , State)	al Route Number,
	ne Hospita n 24 hours ne Funeral pletely fille	Medical C	29a. Certifier (Check only one)  Check only one)  CertifyIng Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
	To t withi To ti	M	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,	
)	15		30. Name and address of person who completed cause of death (Item 23a) (Type,	D53462		5/23/0-	7
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 3 2007  A Registrar's Signature	Print) DAYWOOD ROPE	4 Glei	n Burnie	WD 31061
	The second second						

Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month May 16, 2007 Helen Niess Stehling /Medical 10:30PM<sup>™</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring House Montgomery <u>Bethesda</u> 5. Social Security Number If Under 1 Year Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F Yrs. Director 81 060-22-4533 May 16, 1926 New York Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified Directo 1 ☐ Yes 2 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 West Coquelin Terrace Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: 3 X Widowed 4 ☐ Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl M. Bauer Luella Niess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trauonce. 440 Utterback Store Road Great Falls, Virginia 22066 Date 20c. Location · City or Town, State Andrew A. Stehling/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 4 Donation 5 Dother (Specify) 18, 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase 1 Inc. 7557 Wisconsin Avenue 21. Signature of Fure al Service Licenses Bethesda-Chevy Chase, Inc Bethesda, Maryland 20814-M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician Breast Cancer** 5 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) physician Physician/Medical attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 \(\subseteq\) Yes 2 \(\overline{\Omega}\) No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records. P.O. Box 68760. after death Director: To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Medical

Be ပ္ Certification:

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

5 Pending investigation

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 A Natural

2 Accident 3☐ Suicide

4 Homicide

29a. Certifier

6 ☐ Could not be

and manner stated.

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28c. Injury at Work?

29d. Date signed (Month, Dav. Year)

May 17, 2007

death?

1 TYes

2□ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

Y0215 Fernwood Road #100A Bethesda, Maryland 20817

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one,

2 X No

28d. Describe how injury occurred

Lee Pennington 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature 2007



		ı	1 _ Stata	State of Marylan		artment of H rtificate of L			6.001	16708
	_		Registrar  1. Decedent's Name (First, Middle, Last)			tineate or b	Jean	2. Date of Death	J. No.	3. Time of Death
	Physicia	an		L 41				Month	Day Year	
	/Medic		Lyudmila K. Sapozl 4a. Facility Name (If not institution, give si			dh Cihi Tour as	Logating of Dooth	May 16	4c. County of Deatl	2:10 A M
	Examin	er	Hebrew Home of Gr		rton	4b. City, 10wii, 6i	Location of Death	0		
			5. Social Security Number 6. Sex			If Under 1 Year	Rockvill If Under 24 Hrs.		Montgom	
	Funeral Director			M 2日 68	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) May 26,	1938 Rus	nplace (State or Foreign untry) 3518
	and		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	f sho	ō	Maryland Montgom	erv		Potor	mac			1 ☐ Yes 2 ☒ No
	the t	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
	with		1116 Halesworth Dr	ive			20854		United S	•
	ns 23	Funeral		12. Was Decedent Ever in U	.S. 13. \	Was Decedent of Hi		ecify Yes or No-	14. Race - Amer	
	fter o	필	1 ☐ Never Married 2⊠ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	1	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
ဗ္ဗ	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: W	hite
21215-0036	2 ho	Completed	15. Decedent's Educ		16a. Deced	dent's Usual Occupa	ation	10	6b. Kind of Business/I	ndustry
2	thin 7	Pe	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of DO NOT use retired,	) ()	rig	Scienti	fic
7	er th	Son		5-+	Depa	rtment Di	irecter		Institu	tion
힏	al Hy al Hy l oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>a</u>	Venti Venti rrked	10	Kuzma P. Savinov				Yevgeni	a N. Har:	itonova	
al	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23e or 28e-f show reumatic event, the Medical Examinet must be notified at		19a. Informant's Name/Relationship (Typ		1				City or Town, State, Z	
Σ	and 2 salth n 27 i		Valeriya G. Ignato				ch Drive,	Potomac,	Maryland	20854
ore.	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If the file and Mental Hygiene.  If the 21 is marked other than "neturel, or thems 23e or 28e-f show or other treumatic event, the Madical Examinations to collect the notified at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Dispo emetery, cren	sition (Name of matory or other place	a) _	Date 20	Oc. Location - City or	Town, State
Ĕ	Page nent ant: If		' 4 □ Donation 5 □ Other (Specify)	emovar from State	Parkla	wn Memori ark	al May 1	3,2007 R	ockville,	Maryland
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre 2006.		21. Signature of Funeral Service License	M01	.433 Ro	Name and Address ckville,	Inc. 300	West Mor	umphrey Funtgomery A	neral Home venue
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	Pnysician		Immediate Cause (Final		C-1	11 1	- h 1	700-		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	11 - J	aros	1126	222	
	Examiner		I .	Emale	~.0.~	oc. Th.				
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3760,	ate be executed hysician and he burial-transit	Ical	d.							
89	The law requires that the death certifical tite has been signed by the attending phoage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:							
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Е	ed fo	Sici	in the past 12 months?	4☐ Pregnant at time of d 9☐ Unknown		Other (specify)			Month	Day Year
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p.	w require been sig should b	ted	Dementia					1 L Yes	2 □ No 3 □ Pro	bably 4 Dinknown
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		Con	Hypertensio	ermia				performe	ed? 🧪 death?	2 No
<u>=</u>	icien: Th certificate rector, pag	Be (	25. Was calse leterred to medical				26. Place of Death	(Check only one)		
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$\sim$	y in his		27. Manne Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred	
0	ng Phys Ifter this		1 L Matural 5 ☐ Pending	(Wichilli, Day 10al)	II IJUI y		* 1			
sion o	tending Phy eath. or: After this the funeral d		1 Latural 5 Pending 2 Accident investigation				Yes 2 □ No			
ivision o	or Attending Physicien: fter death. iriector: After this certifics n by the funeral director.			28e. Place of Injury - At he building, etc. (Specif	ome, farm, str		Yes 2 □ No	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
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100	Physicia	an	Jusey	A., Middle, Lasi	7	rder					Month May	2 Day	Year 7	3110 0	
1	/Medic		4a. Facility Name (If not	institution, give		A		4b. City, Town, or	Location of	of Death	1-100	-	County of Death		
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7.0	Funeral		5. Social Security Number	er 6. Se		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	B. Date of Birt			place (State or Foreign	
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ם	be fill d oth	Be	17. Father's Name (First								(First, Middle,	Maiden S	Sumame)		
yla	should Ind Meni	P	John F. B								Ayers				
<b>Jar</b>	2 sh and ls m		Robert F. Sn			hand	19b. Maili	ng Address <i>(Street a</i>	and Numbi a <b>r</b> k Ro	er or Hural oad . (	Route Number	sr, City or Sbur	own, State, 2	1and 20877	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other then "natural; or Items 23s or 28s-f show or other traumatic event, the Medical Examinal mantical training at	1	20a. Method of Dispositi		L • / 11d3	20b F	Place of Dispo	sition (Name of			ate		cation - City or		
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Ba	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 20058.		1 Kuf	Sand	_	M001							e/Rockv 11e, MD	ville, Inc. 20850-2805	
334			23a. Part1. Enter the di shock, or heart fail	sease, or comp lure. List only o	lications that one cause on	caused the deat	h. Do not en	ter the mode of dyin	g, such as	cardiac o	respiratory a	rest,		Approximate Interval Between	
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et a	the name of the na		31. Date filed (Month, D	la Sere	101	Russel Registrar's Sign	A HU	5 Vaceth	2556	ens	mo	50	13-7-7		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ann McGlinn Stillwell 2007 20 $A^{M}$ 5:45 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 10908 Larkmeade Lane Potomac If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) November 4, 1951 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 172-44-0894 Director 55 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ural", or Items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10908 Larkmeade Lane 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: White 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygiene. Chief Operating Officer Global Public Affairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank McGlinn Louise Lea ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau once. Lee J. Stillwell / Husband 10908 Larkmeade Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place) Potomac United Methodist Church Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 23, 2007 4 ☐ Donation 5 ☐ Other (Specify) Potomac, Maryland 22 Name and Address of Facility Robert A Bethesda-Chevy Chase Inc Bethesda, Maryland 20814 Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature of Funeral Service License M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Non Small Cell Lung Cancer 24 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or darrying Cause (Disease or injury that initiated as cort.) Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending for use as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.0. ed by the a 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate has page 2 s autopsy 2 X No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ၉ 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 ☐ Pending investigation Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

the

30

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty M.D. 9707 Medical Centery Drive, #300, Rockville, MD 20850 31. Date filed (Month, Day, Year)

Joseph M. Haggerty Mil

MAY 2 3 2007

(Check only one)

29b. Signature and title of certifier



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32407

29d. Date signed (Month, Day, Year)

May 21, 2007

Physician

Security Products    Security Products   Secur		Examin	er	i i		of Bodrin					or Location	of Death		40.0	Jounty o	r Death
21.6 - 34 - 3318   I		Funeral		5. Social Security	Number 6.	Sex 7.	Age (In yrs. I	last birthday)	If Unde	er 1 Year	If Under		8. Date of B	Birth Dav. Year)		9. Birthplace
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Examiner    Due to (or as a consequence of):			1	d sease or condi	ition				,							j
Due to (or as a consequence of):    Second   Sec	-		,	resulting in death	"	Due to (or	a a conseq	uence of):								
Due to (or as a consequence of):    Second   Sec	^	d #	iner	Sequentially list if any, leading to cause. Enter Un	conditions, immediate inderlying		as a conseq	uence of):								-
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The state of the s		the death certific the attending p	ysician/Mec	23b. Was deced in the past 1 ☐ Yes	12 months? 2 □ No	1 □Live birt 4□Pregnar	h 2 ∐Feta ntattime of d	al death 3	n 3 ∐Ectopic pregnancy Month							
24a. Was an autopsy performed?   1   Yes   2   Mo   1   Yes   2   Yes   2   Mo   1   Yes   2   Ye		uires that signed by Id be deta	þ	Part II. Other significant containing to dealing out for resoluting in the disconying states given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given in a disconying state given												
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The state of Death of the Control of	ā	n: Ti ficate or, pa	ပ္သ	25 Was case re	afarred to medical						26 Place	o of Doot			1	∐Yes 2M
27. Manner of Death 1 Matural 2 Macident 3 Suicide 4 Homicide 28a. Date of Injury M 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Mork? 1 Mork? 1 Mork? 1 Mork? 2 Mork. 2	Š	/sicia s cert lirect	O B	examiner?		Hospital: 1 In	patient 2 □	ER/Outpatie	nt 3∏ [	DOA C	thor				S □Othe	er (Specify)
29b. Signature and title of certifier  29c. License number  29d. Accident Signature and title of certifier  29d. Date signed (Month, Day)	on or	ding Phy n. After this funeral o	ion: T	27. Manner of Do	eath 5 ☐ Pending	28a. Date of (Month)	Injury	28b. Time	of	28c. In	jury at ork?					
The state of the s	Divisi	or Atten after deat Director:	ertifica	3 ☐ Suicide	6 ☐ Could not		f injury - At he g, etc. <i>(Specii</i>	ome, farm, st					28f. Location City or	(Street and Town, State)	d Numbe )	er or Rural R
The state of the s		Hospita 24 hours Funeral etely fillec		(Check only	1 Certifying 2 ☐ Medical Ex	caminer: On the bas	sis of examina	owledge, dea ation and/or i	th occurre	ed at the	time, date a y opinion, de	and place, eath occur	and due to the ting	he cause(s) ne, date and	and mai I place, a	nner as state and due to th
		To the within To the Compl	Me	29b. Signature a	and title of certifier				2	29c. Lice	nse number			29d. Dat	e signed	(Month, Day

Marie

1. Decedent's Name (First, Middle, Last)

14. Race - American Indian, Specify: Black 16b. Kind of Business/Industry Home Maiden Surname) City or Town, State, Zip Code) ore, Md 21214 20c. Location - City or Town, State Randallstown, Md more, Md 21215 Approximate Interval Between Onset and Death 1 Day 23d. Date of delivery Year bacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No an isy rmed2 2 ☑ No ence 6 Other (Specify) ow injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

3

State Registrar

Ivene

31. Date filed (Month, Day, Year) MAY 2 3 2007

Hao

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Smith

2. Date of Death

13

200? 4c. County of Death

May

7:52 PM

Birthplace (State or Foreign Country)

NC 10d. Inside City Limits X□Yes 2□No

			_ FOI	ertificate of Death	, 0	g. No. 2 () () 7 () 7 () 7	1 6		
8	Physici	an	Decedent's Name (First, Middle, Last)     MOSES	CIFCE	2. Date of Death Month	Day Year			
	/Medic		4a. Facility Name (If not institution, give street and number)	SIEGEL  4b. City, Town, or Location of Death	MAY 2	1 2007 4:10 A	М		
			HOSPICE OF BALTIMORE GILCHRIST CTR.	TOWSON		BALTIMORE			
	Funeral Director		5. Social Security Number  052-12-1683  Usual Residence of Decedent  6. Sex  1  M 2 F 89  7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 1)		eign		
	ryland how Lat	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Lii			
	the Ma 28a-f s	ecto	MD BALTIMORE BALT  10e. Street and Number	I MORE	100	1 ☐ Yes 2 ¥	]No		
	3a or	Funeral Director	725 MT. WILSON LANE APT. #823	10f. Zip Code 21208	100	U.S.A.			
	tems 2	uner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2XX No Specify:		Specify: WHITE			
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717	be filed within 72 ho ital Hygiene. d other than "natun event, the Medical	ошо	Elementary/Secondary (0-12)   College (1-4or 5+)	DO NOT use retired)	U	. S. NAVY DEPARTME	NT		
B	be filectal Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)			
Z		မ	LOUIS  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	ANNA  Iling Address (Street and Number or Rur	ral Route Number	SCHWARTZ			
Z	s 1 and 2 should f Health and Mei item 27 is marke other traumatic						าย		
saitimore,	g = 5		20a. Method of Disposition 20b. Place of Dis	ematory or other place)	Date 20 22/2007	-BALTIMORE, MD 2120 Oc. Location - City or Town, State BENSALEM, PA	70		
	그두루루		Donation 5 ∐ Other (Specify)	22. Name and Address of Facility		•			
ğ	Depar Impor any ir		Value Wemin			IKESVILLE, MD 21208	3		
	= *		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.						
i L	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ryngeal CI	Acine	ma gedk			
	Examiner								
1	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
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58/50,	rtificate be ng physicia as the bur	ledical	d						
	± 0 €	/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery			
. BOX	death e atten	sician/N	in the past 12 months?  1 Yes 2 No  No  No  No  No  No  No  No  No  No	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year			
7. 5	w requires that the death cer been signed by the attendin should be detached for use	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did toba	acco use contribute to the cause of death	?		
ecords,	quires t n signe	d by				Yes 2 No 3 Probably 4 dunknow			
eco	a 35	Completed			24a. Was an autopsy	24b. Were autopsy findings avail	able		
<u> </u>	sician: The law certificate has b irector, page 2 s	Com			performe	ed? death? No 1 Yes 2 No	01		
vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Other:	th <i>(Check only one)</i>	ce 6 Sother (Specify)	>-		
п 0			27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	of 28c. Injury at	28d. Describe how		u		
VISION	ten eath tor: the	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm.	M 1 Yes 2 No	28f Location (Stre	eet and Number or Rural Route Number,			
2	al or A s after of in by	Certification:	4 ☐ Homicide determined building, etc. (Specify)	troot, ractory, office	City or Town,	State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)			
	To the vithin To the compl	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)			
1			If the thing thely us	125205	N	14721,2007			
	12		30. Name and address of person who completed cause of leath (Item 23a) (Typ	1. Print) Charles St.	Balto.	MY 5130 k			
	Sta		31. Date filed (Month, Day, Year)  MAY 2 3 2007  32 Registrar's Signature	29c. License number DJ SJOS A. Charles St.					
DH	Registr MH 17 Rev 1/20		MAY 2 3 2007 Decen 25 19						
_ ,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5.15 A RUSE SCH USTER 2 05 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 5. Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 X F 09/28/1917 MD Director 218-46-2046 89 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6905 JONES VIEW DRIVE, #2B 21209 USA death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglenn Important: If Item 27 is marked other that any Injury or other traumatic event, the one. SOCIAL SECURITY CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SCHUSTER LENA HYATT ဂ JACOB 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6905 JONES VIEW DRIVE, #2B, BALTIMORE, MD EILEEN LIPSKY / NIECE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition ZICHRON CABRAHAM (NACHMAN CONGREGATION 05/22/2007 BALTIMORE, MD 1 X Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility √f Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Cardonespira **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse dence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Whknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 npatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

BOONYUNG F. THADA, M.D 31. Date filed (Month, Day, Year) MAY 2 3

29b. Signature and title of certifier

53.56 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REISTERSTOWN RD. BALTIMORE, MD 2215

29c. License number

019823

29d. Date signed (Month, Day, Year)

5/21/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 2005 Month Physician your EDWARD LEE SINGLETON /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Balhmore N/A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1**XX**M 2□ F 65 FLORIDA JUNE 6 1941 Director 261-64-8702 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1XXYes 2 □ No be notified Director BALTIMORE N/A MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 U.S.A. "natural", or items 23a 3627 LIBERTY HEIGHTS AVENUE 21215 Examiner must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2XXXIII Baltimore, Maryland 21215-0036 Specify: BTACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CARPENTER permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If Item 27 is marked other the 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ETTA MAE GAYE EDWARD SINGLETON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3627 Liberty Heights Avenue, Balto. Md., 21215 Mercedes Singleton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State GREEN MOUNT CEMETERY 05-23-07 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. erbara 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER wee K **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit be executed Records, P.O. Box 68760, attending physician for use as the buria foreted Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 21 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Inpatient ၉ 27. Manner of Death 1 □ Natural 2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: 5 ☐ Pending investigation (Month, Day Year) injury 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral C completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

3

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	State of Marylar		artment of r <i>tificate o</i>		-	giene Reg. No	2007	16715
	Physicia	an	1. Decedent's Name (First, Middle, Las		on			2. Date of De Month	Da	y Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	chard A. Tov	en	4b. City, Town	, or Location of Deat	May 1		. County of Death	5:30 A M
	_xaiiiii		15201 Wycliffe C	ourt		Ŧ	ckville			Montgome	
·	Funeral Director		5. Social Security Number 6. S 190–30–8100	ex 7. Age (In yrs 69	. last birthday) Yrs.	If Under 1 Ye Months Day			y, Year)	938 Penn	place (State or Foreign ntry) sylvania
ī	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				Ţ 1	0d. Inside City Limits
	Maryl I-f sho fied a	tor	Maryland Montgom	ery	Rockvi	.11e					1 ☐ Yes 2 No
	or 282	Directo	10e. Street and Number			10f. Zip Code			_	tizen of What Cour	-
	eath w	Funeral	15201 Wycliffe (	Ourt  12. Was Decedent Ever in U	IS 13	2085		Specify Yes or No		ted State	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No 56 If Yes, Give Year or Dates:	-60	If Yes, specify C 1 ☐ Yes 2【X】N	of Hispanic Origin? (S duban, Mexican, Puèr No <i>Sp</i> ec <i>ify:</i>	to Rican, etc.)		Black, White, Specify: W	etc. nite
215-0036	72 hoi 'natur	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a. Dece	dent's Usual Oc kind of work do	cupation ne during most of wo ired)	rking		ind of Business/In	
2121	within ene. than '	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		ms Anal			_	ernment	.05
מפר	al Hygi other vent, t	Be Co	17. Father's Name (First, Middle, Last)	)			18. Mother's Na	me (First, Middle	, Maider	Surname)	
Maryland	ould by Menta	To	Anthony Toven					lancuso			
Mar	d 2 sh th and t7 Is rr traurr		19a. Informant's Name/Relationship ( Emelie L. Toven		T	•	eet and Number or R fe Court,				<i>'</i>
re,	s 1 an of Heal Item 2		20a. Method of Disposition	20b.		osition (Name of matory or other		Date		ocation - City or To	
altimore,	Page ment cant: If		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) Mor	ntgomery	Crematori	um, Inc 20	19 <b>,</b> 007		hesda, Ma	
Ball	permit Depart Import any Inj once.	di V	21. Signature of Funeral Service Liogn	1x/v/	Rc 30	2. Name and Ad bert A. P 10 West Mo	dress of Facility Tumphrey Fund Intgomery Ave	eral Home/ enue, Rock	Rock Ville	ville, Inc. Maryland	
			23a. Part1 Finter the disease, or comshoots or heart failure. List only			ter the mode of	dying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lung Cano							18 Months
	Examiner		Sequentially list conditions	b							
./	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a conse	quence of):						
×, ,	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	C Due to (or as a conse	quence of):						
58760,	icate be executed physician and the burial-transit	dical		_d							
_		0	IF FEMALE:	23c. If yes, outcome pf pregi	nancy					23d. Date of deliv	env
P.O. Box	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	⊒Ectopic pregna ⊒ Other (specify			Month Day Year			
	uires that signed by id be deta	by	Part II. Other significant conditions of	contributing to death but not re	inderlying cause		e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
Records,	aw require s been sig 2 should b	Completed						24a. Was		24b. Were auto	opsy findings available
E E	ding Phystcian: The lav n. After this certificate has funeral director, page 2	Som						auto pert 1□ Yes	ormed?	death? o 1 ☐ Yes	ompletion of cause of 2 ☐ No
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Other:	ath (Check only			
ō	g Physer this eral di	n: To	1 ☐ Yes 2 ☒ No  27. Manner of Death	28a. Date of Injury	28b. Time	III JU DON	4∐ Nursing njury at Work?	Home 5 (A) Res 28d. Describe		6 ☐Other (Special occurred)	fy)
Sion	Attending r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		Injury		1 ☐ Yes 2 ☐ No				
Division or Vital		Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		reet, factory, offi	ice		on (Street and Number or Rural Route Number, Town, State)			
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	edical		nysician: To the best of my ki miner: On the basis of examinated and manner stated.							
	To the within To the comple	Mec	29b. Signature and title of certifier	7		29c. Lic	ense number		29d. Da	ate signed (Month,	Day, Year)
)			1 Mount	nyono			D23308		May	15, 200	7
	1401		30. Name and address of person who				e,#4100, I	Rothoods	W	ruland o	0.81.7
	Sta	ite	Victor M. Priego 31. Date filed (Month, Day, Year)	32. Registrar's Sig		Re DUIA	ະ <b>,</b> #4100 <b>,</b> 1	Je LHESQA	, Ma	тутани 2	001/
	Registr	ar	MAY 2 3 20	1 389 ARD A	7- 6-24	weer.					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland	•	artment of F		nd Mental Hy	gien Reg. Ne	2007	16716
	Physici		1. Decedent's Name (First, Middle, Last Charles Anthony To		-				2. Date of De Month May 21	Da		3. Time of Death 5:18 A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of			. County of Death	
			Wilson Health Care	Center			Gaithers	sburg		N	Montgome:	ry
10 cq	Funeral Director		5. Social Security Number 6. Se 012-14-8997	X 7. Age	9 (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Bin (Month, Do. Jan. 5,	rth ay, Year	9. Birth Con Mass	place (State or Foreign untry) achusetts
Т	p .		Usual Residence of Decedent  10a. State 10b. County		10a Cibi	Town or Lo						404 1-141 01-11-11-
	death with the Maryland ms 23a or 28a-f show Inval to notified at	ō	Maryland Montgome	ry		hersb						10d. Inside City Limits 1 AYes 2 No
	28a-f	Director	10e. Street and Number	-			10f. Zip Code			10a C	itizen of What Co	
	aa or		333 Russell Ave.,	#622			20877			-	ed State	,
	ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. \		lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Amer	ican Indian,
0030	be filed within 72 hours after death with the Marylan ital Hygiene od other than "natural", or Itama 23a or 28a-f show svent, Ita Medical Exactinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1    Yes 2   If Yes, Give Year or Dates:	o wwii	_	Yes, specify Cuba	Specify:	Puerto Hican, etc.)		Black, White Specify: Wh	ite
Ş	2 hou	ted	15. Decedent's Edu	cation		16a. Deced	lent's Usual Occup	ation		16b. h	(ind of Business/i	ndustry
2 2	thin 7	Completed	(Specify only highest grad	College (1-4or 5	+)	life. l	kind of work done OO NOT use retired	during most o	or working			
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and	buld be fil Mental H arked ott atic sver	Be	17. Father's Name (First, Middle, Last)	7.22					s Name (First, Middle			
2	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic sve	ဥ	Charles Joseph Tob  19a. Informant's Name/Relationship (7)			19h Mailin	a Address (Street		to Dean Co			in Code)
Z	D = C =		Daniel J. Tobin /						Potomac,			
ā,	f Healitem		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other place		Date		ocation - City or 1	
Ē	Pages nent of int: If it		1 ☐ Burial 2 【③Cremation 3 ☐ B 4 ☐ Donation 5 ☐ Other (Specify)				rematorium	11100	y 24, 2007	Betl	nesda, M	arvland
	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		21. Signature of Funeral Service Licens	88					uneral Home/			
מ	88 = 8		1 7.8.00	<u> </u>	00896				ve., Bethe			
			23a. Part1. Enter the disease, or comp shock, or heart fallure. List only o									Approximate Interval Between
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õ	ding pl	a a	IF FEMALE:		2000				1 11 11 11 11 11 11 11 11 11 11 11 11 1			
X O D	Seath certific attending p	Physician/M	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy	,			23d. Date of deli-	very Day Year
j	y the	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time or dear	ın 5L	Other (specify)					
T.	wrequires that the de been signed by the should be detached	by Pr	Part II. Dther significant conditions co	ntnbuting to death b	at not resulti	ing in the ur	iderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
coras,	quire; an sign uld be	ed b	Despertens	in. h	ypo	th	graid	esm	<u>C</u> , 10	Yes 2	Pro 3□Pro	bably 4 Unknown
) ၁	law re	plet	Renalfail	use, 4	nees	nik	, Rodi &	times	Lites 24a. Was		24b. Were aut	opsy findings available
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V 11.0	cian: ertific actor,	Be (	25. Was case referred to medical examiner?					26. Place o	f Death (Check only			
5	Physi this c	10	1 ☐ Yes 2 ☐ No		nt 2 EF			4 PNUIS	ing Home 5 ☐ Resi			ify)
5	ding F h. Atter funera	:lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28	8b. Time of Injury	28c. Injur Wor M 1		28d. Describe	how inju	ry occurred	
114151	Attendi death. ctor: A y the fu	fical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ary - At home	e farm str		Yes 2 □ No		Street a	nd Number or Ru	ral Route Number.
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	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director Atter this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the timestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s	and manner as d place, and due	stated. to the cause(s)
	Fo the vithin 2	Med	29b. Signature and title of certifier	and maillier Sta			29c. Licens	e number		29d. Da	ate signed (Month	, Day, Year)
	, (		14. Robert	kirsel.	hu -	Pus	d De	3411	5	M	u 21.	2007
	1201		30. Name and address of person who co	ompleted cause of d	eath (Item 2	3a) (Type,	Print) 20	1 RU	S SSELL ERSBUR	40	Evue	
-1	1.		W.ROBERTBIR				, 64	-174-2	RSBUR	6,2	200	844
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 3 200	36. Registra	ir's Signatur	for	de la					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5 2007 vene /Medical Cornelius 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **№** M 2□F 74 162-26-6856 Yrs. 10-10-1932 VA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Windsor Mill Baltimore MD Directo 10g. Citizen of What Country? 10e Street and Number USA 21244 3630 Valley Terrace, Apt.2B Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married ¾☐ Married African-1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WSSC Santitation 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Darby John G. Veney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21244 19a. Informant's Name/Relationship (Type. Print) 3630 Valley Terrace, Apt. 2b, Windsor Mill Clarice L. Veney/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Park 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5-23-07 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signar re of Funeral Service Licensee 22. Name and Address of Facility  $Wylie\ F/H\ P.A.\ of\ Balto.\ Co.$ 9200 Liberty Rd., Randallstown, MD 21133 audane Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner hacme OAStructur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown H - an+ Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No filled in by the funeral director, page 2 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Alle 021085

Registrar

State

000

5310

ا د د الرحالية 32. Registrar's Signature

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
MAY 2 3 2007

voisio		Registrar  1. Decedent's Name (First, Middle	e, Last)			rtificate of		2. Date of D	Reg. Nd eath Day		3. Time of Dear
iysiciar Medica kaminei	r 4	Shady Grove Acts. Social Security Number	n, give street and	Hospita	al.		ockvill	May eath	17,	2007 County of Dea Mon	tgomery
neral ector		265-76-9622 Usual Residence of Decedent	1 M 2 X		s. last birthday, Yrs.	Months Days		8. Date of B (Month, D			thplace (State or For ountry)  Cuba
De notified at	_		ntgomer		City, Town or L	Montg	omery V	illage			10d. Inside City Lin 1 X Yes 2 □
Examiner must	by Funeral	10e. Street and Number  9805 Me  11. Marital Status  1 Never Married 2 Marr  3 X Widowed 4 Divorced	ned 1 7	Ft Lane Decedent Ever in 1 Forces; es 2 XNo , Give or Dates:	U.S. 13.	Was Decedent of Hif Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)		Unite 14. Race - Ame Black, White	d States
vant, the Madical	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 12	st grade complet	<i>ed)</i> ge (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retire Homen	during most of v d)	vorking	16b. K	ind of Business Own	/industry  Home
r other traumatic avant,		17. Father's Name (First, Middle,	nio Pere	z Bartol		ing Address (Street	18. Mother's N	lame (First, Middle	Herna	Sumame)	aguerio
any injury or oth		20a. Method of Disposition  1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S  21. Signature of Fup (al Service)	pecify)		of Hear	osition (Name of smatory or other pla Gate ven Cemet	erv 22	May 2, 2007	Silv	ver Spri ohrey F	no. Marvi
cian		23a. Part1. Enter by disease, us shock, or heart failure. List Immediate Cause (Final disease or condition death)	m I tions the		ath. Do not en		e, Inc. e, Mary	300 West land 208 iac or respiratory	t Mot 50–28 arrest,	itgomery 305	Approximate Interval Betwee
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cian lical iner	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. A Due  b. G Due  c. D Due  d	nat caused the decon each line.  spiratio to (or as a consect to (	on Pneus equence of):  sequence of):  equence of):  equence of):	nter the mode of dyi	ng, such as card	300 West Land 208	arrest,	23d. Date of de Month	Approximate Interval Betwee Onset and Dea Hours Months Months
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			For State	State	of Marylar	•	artmer rtificat			and M	-		000	( , m m) 1 /N
			Registrar  1. Decedent's Name (First, Middle, La.	st)			Tinout		Journ		2. Date of De	Reg. No.		3. Time of Death
H	Physicia /Medic		Mildred E. Va	,	iessche						May 17			11:48 A M
3	Examin	er	4a. Facility Name (If not Institution, giv		,				Location o	f Death			County of Death	
12			Shady Grove Adven			land bindbalard		ockvi r 1 Year	lle If Under 2	DA Hrs	8. Date of Bir		Montgome	Place (State or Foreign
1	Funeral Director		5. Social Security Number 6. S 215-26-9498	ex □M 2∏X F	7. Age (In yrs. 79	. iast birthday) Yrs.	Months		Hours	Min.	(Month, Da May 5,	ıv. Year)	Cou	place (State or Foreign Intry) Land
	p		Usual Residence of Decedent		1									40.1.1.1.00.1.1.1
	rylan thow	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d, Inside City Limits 1 M Yes 2 □ No
	e Ma 3a-f s tifflec	cto	Maryland Montgome	ery	Ro	ckvill	e							
	or 24	Director	10e. Street and Number					p Code					en of What Cou	·
	ath w		682 College Par				_1	0850					ted Stat	
	tems	Funeral	11. Marital Status	Armed F		J.S.   13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)-	Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	i 2∭ No Give Dates:		1 🗌 Yes	2K No	Specify:				Specify: W	nite
215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		15. Decedent's E			16a. Dece	dent's Usu	ial Occupa	ation			16b. Kir	nd of Business/I	ndustry
5	in 72 n "ne Aedic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed	() (1-4or 5+)	(Give	kind of we DO NOT u	ork done d ise retired	during most )	t of worki	ng			-
212	with giene r thau the h	E	Elementary/Secondary (0-12)	2	(1-401 5+)	Adm	inis	trati	ve As	sist	ant	U.S	S. Gover	nment
פ	al Hyg othe	Be C	17. Father's Name (First, Middle, Last	)					18. Mothe	r's Name	(First, Middle	, Maiden l	Surname)	
<u> </u>	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hyglene. The street and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item traumatic event, the Medical Examiner must be notified at	To E	Cormany G. Bro	bst						Carı	cie B.	West		
lan	2 sho and Is ma auma		19a. Informant's Name/Relationship (	Type. Print)			-					-	Town, State, Z	
≥ .	and ealth m 27 ner tr		Dean Vandendries	sche/H									Maryland	
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal fror	ii State	Place of Dispo cemetery, cre				June			cation - City or T	· —
Ξ	tmen tant:		4 Donation 5 Other (Special		Ar	lington				20	07	Arli	ngton,	Virginia
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	Amp.	hus	Ro 30	bert 1 0 W.	nd Addres A. Pun Montg	ss of Facilit phrey omery	Fune: Avenu	ral Home e, Rocky	, Rocl	kville, I Maryland	nc. 20850
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on	caused the dea	th. Do not en	ter the mo	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Ch	ronic Ol	struct	ive	Pu1mc	nary	Dis	ease			Onset and Death 5 years
d	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):								
	LAMITHIE	_	Sequentially list conditions,	b. — Due t	o (or as a conse	anence of).								
	ted sit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o (or as a conse	quence oi).							- 9	
	execu al-tra	Examiner	that initiated events resulting in death) Last	c Due to	o (or as a conse	quence of):								
8760	icate be executed physician and s the burial-transit	dical		d										
ထ		ledi										T		
Вох	leath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregr		∃Ectopic	oregnancy	,			2	23d. Date of deli	•
	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	sician/Me	in the past 12 months? 1 ☐ Yes 2 🎇 No		gnant at time of		Other (s						Month	Day Year
P.0	at the ded by the a	Phy	9 ☐ Unknown  Part II. Other significant conditions		-	culting in the u	andorbina.	oauso aku	on in Part I		23e Did	tobacco u	se contribute to	the cause of death?
ŝ	w requires that been signed k should be det	by	Coronary Artery			suiting in the t	indenying	cause giv	en in Fait i					bably 4 □Unknown
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Division or Vital Records,	ne law has t ge 2 s	Completed by	Bowel Obstruction	711							24a. Was	psy	prior to death?	topsy findings available ompletion of cause of
a											perf 1∐ Yes			2 No
₹	<b>hysician:</b> The la his certificate had I director, page 2	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	∏Inpatient 2[	TER/Outpotio	nt 2 🗆 D	OA Oth	er.		h (Check only		7 Cother (0	
ō	Phy r this ral di		27. Manner of Death	28a. Dat	te of Injury	28b. Time o		28c. Injur Wor			28d. Describe		G ☐Other (Spec y occurred	:iry)
0	ttending Phy Jeath. :tor: After thi	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		onth, Day Year)	Injury	М		k? Yes 2 □	No				
<u> S</u>	Atter r dear ector by the	iţica	3 Suicide 6 Could not be determined	20e. Fla	ce of injury - At I	home, farm, st	reet, facto	ry, office	- 5	-	28f. Location	Street and	d Number or Ru	ral Route Number,
á	al or al or	Certification:	4 Ditionicide	Dui	iding, etc. (opec	aty)					Only of 10	wii, State,	,	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical (	29a. Certifier 1 \(\bigcit \) Certifying P (Check only one)	mines: On the										
	ro the vithin routh of the somple	Me	29b. Signature and title of certifier	/		4	25	9c. Licens				29d. Dat	e signed (Month	n, Day, Year)
	/		East to	2 for	and 1	Mo		D265	40			May	17, 200	7
	,5		30. Name and address of person who	completed ca	use of death (Ite	em 23a) (Type	, Print)							
	,		Carl I. Schoenber	ger, M	.D. 16	220 Fre	ederi	ck Ro	oad,	Gait	hersbur	g, M	aryland	20877
3	Sta Regist		31. Date filed (Month, Day, Year)	07	Registrar's Sig	pature	de							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Dep			Mental Hygie	ene 1. No 2 0 0 7	16720
п	Physici	an	1. Decedent's Name (First, Middle, La Elizabeth	st)	īa7 i	lliams		2. Date of Death Month	Day Year	
	/Medic	al	4a. Facility Name (If not institution, giv	a street and sumbas)			or Location of Death	5 19	2007 4c. County of Dea	10:37p <sup>M</sup>
<i></i>	Examin	er	820 S. Caton A				Baltimor		N A	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bi	nthplace (State or Foreign
П	Director		215-28-5887	□M 21XF	78 Yrs.	Months Days	Hours Min.	10-26	-1928	N.C.
	pu 💌		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Le	nation				10d. Inside City Limits
	ehov	ក		NA		Baltimor	^_			1 ☑ Yes 2 ☐ No
	28e-1	ect	10e. Street and Number		-	10f. Zip Code		100	g. Citizen of What C	**
	3a or	0	820 S. Caton	Ave.		2122	29	13	USA	· · · · · · · · · · · · · · · · · · ·
	me 2	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No-	14. Race - Am	
Q	after or its	E.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0	1 ☐ Yes 3√☐ No		Hican, etc.)	Black, Whi	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow the Maryland Examiner must be notified at	Completed by	3 X Widowed 4 □ Divorced	Year or Dates:					Specify: B	
2	n 72 h "nati	lete	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of world	king 16	6b. Kind of Business	s/Industry
2	withis ene. then	g .	Elementary/Secondary (0-12)	College (1-4or 5-	+)	urse	ia)		Rosewoo	ď
0	filed I Hygie other	Be C	12th grade 17. Father's Name (First, Middle, Last,				18. Mother's Nam	ie (First, Middle, Ma		
Maryland	uld be Aental rked o	To B	Samuel		Jones		Marvi	s	Sattle	white
ar)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If tier 27 is marked othar than "naturs!, or itema 23a or 28e-f show eny injury or other traumatic event, the Marcical Examinar trust be notified at once.		19a. Informant's Name/Relationship (					ral Route Number, (		
	1 and 3 Health tem 27		Twana Warren	Daugh		The second secon	- triby	, Baltim		
ŏ	Pages 1 nent of H int: If ite iry or ot	1	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State	_	matory or other pla	ice)		c. Location - City of	
Baltimore,	it. Pa		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Fervice Licer	-		Ount Ce		3-07 March F.	Baltimo	re, Ma.
Ba	permit. Page Depertment of Important: If ony injury or once.		Brak Mila	4				ve., Bal		Md. 21202
/en:X	The private of a secured with the private of the pr	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DIABETE Due to (or as a MYPERT	consequence of):  S MELL  consequence of):	T DISEASE	5			Onset and Death 6 YEARS 20 YEARS 20 YEARS
.O. Box 68	it the death certific: by the ettending pl	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other (specity) _	у		23d. Date of de Month	olivery Day Year
S,	res tha igned be det	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
0.0	w require been signal							1 ☐ Yes	2 No 3 P	robably 4 🖫 Unknown
Vital Records,	hysicien: The law his certificate has b il director, page 2 sh	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 2	prior to death?	utopsy findings available completion of cause of s
= =	sicier certif recto	Be	25. Was case referred to medical examiner?	Hospital:		Ot	200	th (Check only one)		
DIVISION OF	ing P	ation: To	1 Yes 2 S No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	28b. Time o	f 28c. Inju	4   Nursing H	ome 5 ⊠ Residence 28d. Describe how		9Cify)
5	Nospital or Attend 24 hours after death Funeral Director: A stely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc.		•		City or Town, :	State)	tural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one)	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	vestigation, in my	opinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	To To	2	29b. Signature and title of certifier	M.D		29c. Licen			I. Date signed (Mon	
	1,		Val				0347	(	05 22 2	-007
	N		30. Name and address of person who RAHUL JAIN SAI		ath (Item 23a) (Type, MOSPITAL	_ '	E MD 212	129		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra			- "ID Z [ ]			
	Registr		MAY 2 3 20	Il Sille House	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month John Robert Warthen Mar 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AGNES HEALTHCARE SAINT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | July 20, 1941 Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F 65 Maryland 220-38-7039 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4 Trembly Court 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 🔀 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mailman U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Xavier Warthen, Sr. Florence Nelker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn R. Warthen, Wife 4 Trembly Court, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Metro Crematory 05-19-2007 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke 21. Signature of Juneral Service Licens Funeral Home of Catonsville, Inc., 1630 Edmondson Ave., Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Coronary 2n Known disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 25. Was case referred to male experiments. autopsy performed 1∐ Yes 2 No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Examiner** Box 68760, P.O. Records, Vital ō

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

Show 28a-f sh notified

Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be none.

and 2 should be filed within 72 hours after

Pages 1

**Physician** 

/Medical

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Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

Rylun

me and address of person who completed cause of death (Item 23a) (Type, Print)

7. Agnes 1-32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division ō

To the Hospital of within 24 hours at To the Funeral D completely 0

State Registrar

DHMH 17 Rev 1/2001

Hospita

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

900 Caten Avenue Baltimore

SC

Year

29d. Date signed (Month, Dav. Year)

State Registrar

10

29b. Signature and title of certifie

30. Name and address of person 31. Date filed (Month, Day,

MAY 2 3 2007

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who completed cause of death (Item 23a) (Type, Print)

Bucran

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland				ealth and N D <i>eath</i>		jiene eg. No.) ()	(17	16723
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l	Funeral Director		5. Social Security Number 6. Se 215-30-6810	ox 7. Ag □M 2□xF 7. Ag	e (in yrs. ia 72	a <i>st birthday)</i> Yrs.	Months		Hours Min.	8. Date of Birth June 21	, 1934	Mary	lace (State or Foreign try) land
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show many highly or other traumatic event, the Medical Examiner must be notified at once.	by Fun	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			ifYes,spo 1 □ Yes		n, Mexican, Puerto Specify:	Rican, etc.)	Spec	ack, White, ify: Whi	
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Division	al or Attener after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Flace of In	jury - At ho tc. <i>(Specif</i> )	ome, farm, str	reet, facto	ory, office		City or Tou		mber or Hun	al Route Number,
	To the Hospital or Atter within 24 hours after des To the Funeral Directo completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis of and manner si	of my kno of examina tated.	wledge, deat tion and/or in	th occurre	d at the ti	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and date and plac	manner as s e, and due f	stated. o the cause(s)
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	10		30 Name and address of person who	completed cause of	eath (Item	23a) (Type,	Print)	ous c	Ave	0-1.7	Vede	rick	, md z 1701
9	St	ate	31. Date filed (Month, Day, Year)	32/Regist	rar's Signa	iture	and !	,			_		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12, 2007 Donald Edward Wilt. May 5:00 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1₩ 2□ F Yrs 216-50-6702 Director December 13, 1944 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 √2 Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 202 Baltimore Road 20850 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White δ Specify: 3 ☐Widowed 4 ☐Divorced neturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be George E. Wilt, Sr. Eva Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George E. Wilt, Jr. /Brother 488 Fincher Road, Newport, Tennessee 37821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 17, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville Cemetery Rockville, Maryland 4 ☐Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licenses MO1305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Offer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line, Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) suhythmia **Physician** ninute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 1 Live birth 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Olor 1 Yes 2 No 3 ☐ Probably 4 🗷 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an s certificate has l lirector, page 2 s autopsy performed? res 200 No 1 Tes Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 🗌 Yes 2 ER/Outpatient 3□ DOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Naturat 2 Accident 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medicai 29a. Certifier within 24 ho To the Func completely f On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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MAY 2 3 2007

Orlee Panitch,

31. Date filed (Month, Day, Year)

30. Name and a ress of person & o empleted cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Mary		•	ate of E		vientai n	Reg. N		1 ****	16725
	Physicia	an	1. Decedent's Name (First, Middle, Las						2. Date of I Month May	Death	Day Y	'ear	3. Time of Death
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Baltimore, Maryland 21215-0036	ithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed) College (1-4or 5+)	16a. De (G life	ive kind of v e. DO NOT	sual Occupa work done di use retired)	ition uring most of work	king	16b.	Kind of Busi		dustry
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	1	ŀ	30. Name and address of person who d					MD 0007	6				
	Sta	te.	Humera E. Malik I 31. Date filed (Month, Day, Year)	.9519 Doctor		Germa	intown	MD 2087	0				
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		-	For State Registrar	Sta	ate of I	Maryland	-	artment			and Me		giene Reg. No.	007	16	126
			Decedent's Name (First, Middle	, Last)								2. Date of De. Month	ath \hay	Yeer		of Death
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	Funeral		Northwest Ho 5. Social Security Number	6. Sex	7.	Age (In yrs. la:	st birthday)	if Under	1 Year	stov If Under:		8. Date of Bird		9. B	irthplace (Sta.	e or Foreign
	Director		226-46-6512	XIXM :	2 🗆 F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Bin (Month, Da 10-8-	-19	37	Country) L	A
	and w		Usual Residence of Decedent  10a. State 10b. County			10c. City,	Town or Lo	cation							10d. Inside	City Limits
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	or 28a	Director	10e. Street and Number					10f. Zip	Code				_	en of What (	Country?	
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121	within ine. ihen "	mpi	Elementary/Secondary (0-12)	C	ollege (1-4	or 5+) NA		DO NOT us								
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	/Medical Examiner		resulting in death)		,	as a conseque	. 0					650		0		e Geria
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend #10e Per FH C868 6/19/0©ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>007</u> Month Physician Clarence Eugene Wagaman  $\mathbf{P}^{\mathsf{M}}$ 21, May 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 210-32-7226 63 Pennsylvania Oct. 28, Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show item 27 is marked other than 'natural', or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Baltimore Cockeysville Md. Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10212 Sunnylake Place Apt5 Apt F USA 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 ☐ Widowed 4 🏿 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luella I. Tavlor Clarence E. Wagaman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other traconce. 3869 Whitley Park Dr. Virginia Beach, Va. 23456 Mrs. Kimberly Magruder/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Co. 5-25-07 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Sepoce Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CAN CEX UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and -trans burial-1 Due to (or as a consequence of): Box 68760, attending physician for use as the buris Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.0. the 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Matural 2 ☐ Accident 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 027730 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTHORE, MD. 6569 N. CHARUS 50 conter

Registrar

State

31. Date filed (Month, Day, Year)

MAY 2 3 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 21, **Physician** 2007 4:28 P Young Jr. AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 220-05-5349 Director March 25,1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Inst. If iten 27 is marked other than "natural", or items 23a or 28a-f show mit: If iten 27 is marked other than "natural", or items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at iny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 Brookview Avenue 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No White Specify. 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Tool & Die Maker Can Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert P. Young Sr. Mary Elizabeth Korte 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1700 Brookview Avenue, Dundalk, Maryland Agnes Young 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or May 22,2007 Baltimore City, MD. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. ly 21222 23a. Part1. Enter the diseast of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. The only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Seme disease or condition nenth /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy certificate 2 No 1□ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA DICE

The law requires that the death certificate be executed or Vital Records, P.O. Box 68760, or Attending Physician; this

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of To the Hospitai

Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

one)	and	d manner stated.	n and/or investig	alion, in my opinion, death occu	rred at the time	e, date and place, and due to the ca	:USE
b. Signature and title of cer	Wier	10	0	29c. License number		29d. Date signed (Month, Day, Y	ear)

32. Registrar's Signatu

D D25205 May 21, 2007 701 N. Charles St. Balto. Md 21203

State Registrar

18

31. Date filed (Month, Day, Year)

29

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Zielinskí Jr. 22, Thomas Α. 2007 11:15 A<sup>M</sup> May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Genesis Eldercare- Heritage 8. Date of Birth (Month, Day, September If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** <sup>y</sup>9,1940 Months Days Hours 1 XM 2 ☐ F 66 Yrs. Maryland 214-38-2617 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Director Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 1907 Monroe Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Auto 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas A, Zielinski Agnes Michaels Sr. ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Zielinski wife 1907 Monroe Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. May 25,2007 Dundalk, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. Dundalk, Md. 21222 22. Name and Address of Facility 7110 Sollers Point Road, Dundalk, Md. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, that initiated events resulting in death) Last and Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Aatural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death To the Funeral Director: filled in by completely the

State

Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene /

2. Date of Death

Month

April

Day

29

2007

3. Time of Death

Birthplace (State or Foreign Country)

10d. fnside City Limits

Approximate fntervaf Between Onset and Death

X□ Yes 2 □ No

Alabama

Bfack, White, etc.

Private

Month

29d. Date signed (Month. Day, Year)

Glen Burnie

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

21061

Year

4 Inknown

10:52 A<sup>M</sup>

1. Decedent's Name (First, Middle, Last)

Thelma

В.

Alford

**Physician** 

Division

Medicai

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNERO

MD

ORIGINAL

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(
| Centifying Privation: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DAKWOOD ROBO

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-	Physici /Medic		Laura	Ars	senault						6, 2		8:15	p M
)	Examin	er	4a. Facility Name (If not institution, gi	ve street and number	r)		4b. City, Town, or	Location o	f Death		4c.	County of Dea	ath	
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Ī.,	Funeral Director			1□ M 2∏ F	87	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	0	ountry)	-
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	arylar show	'n	10a. State 10b. County		10c. City, T								10d. Inside (	City Limits s 2 ☑ No
	the M 28a-f	Director	Maryland Mont  10e. Street and Number	gomery	51	Iver	Spring 10f. Zip Code				10a Citi	izen of What C		
	ya or		3910 Minden Roa	đ				0906			Tog. Oil	USA	ountry :	
	death ms 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Speci	fy Yes or No	-	14. Race - Am		
920	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	<b>K</b> No		if Yes, specify Cuba 1 ☐ Yes 2☐ <b>x</b> No	Specify:	, Puerto Ri	can, etc.)		Black, Wh Specilyhit		
2-0	72 ho natur dical	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	1	6a. Dece	dent's Usual Occupa	ation	of working		16b. Ki	ind of Business	s/Industry	
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aŭ	be d d d	9 Be	Luigi Vella	9						Minar		Surname)		
$\overline{\leq}$	2 should and Men is marke aumatic	ᅀ	19a. Informant's Name/Relationship	(Type. Print)	1	19b. Mailir	ng Address (Street a					er Town. State.	Zip Code)	
Š	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		James L. Arsenau	1+ /Son										
e,	of Her of Her Fitem		20a, Method of Disposition		20b. Place	e of Dispo	Minden R sition (Name of matory or other place	1.	$\frac{\text{Dat}}{\text{Dat}}$	$\begin{bmatrix} 1, & \end{bmatrix}$	20c. Lo	ocation - City o	r Town, State	
Ĕ	Pages nent of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 🔀 Other (Spec	Hemoval from State (ify) entombmo	eı						Silv	er Spri	ng, Ma	rvland
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any Injury o	j	21. Signature of Funeral Service Lice	nsee		F:	R. Name and Address rancis J. 00 Univer	ss of Facility Coll Sity	ins F Blvd.					A STATE OF THE STA
, I			23a. Paul. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	ed the death. D								Approxima Interval Be	
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õ	tificate ig phys as the	ledi												
C. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown		e pf pregnancy 2  Fetal de at time of death	ath 3	Ectopic pregnancy Other (specify)				2	23d. Date of de Month	elivery Day	Year
7.	that the ed by detac		Part II. Other significant conditions	contributing to death	but not resulting	g in the ur	nderlying cause give	en in Part I.		23e. Did to	obacco u	ise contribute t	to the cause of	death?
VItal Records,	w requires that the dibeen signed by the should be detached	d by	Chronic Obst			_							robably 4	
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ř	The law te has b	mo	<u> </u>	LLICIA DCD1	ши					autor perfo	osy rmed?	prior to death?	completion of	cause of
<u> </u>	W 77	BeC	25. Was case referred to medical					26. Place	of Death (	1∐ Yes Check only o	2 <b>1</b> No	1 □ Ye	s 2□No	
_	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat	tient 2 ER/	Outpatien	t 3 DOA Othe	ar.				6 □Other (Spe	ecify)	
0	ding Pi		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28i	b. Time of Injury	28c. Injury Work			d. Describe I				,
Sion	tendl eath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	10				Yes 2□N	-					
$\leq$	or At	Certification:	4 ☐ Hornicide determined	28e. Place of in	njury - At home, etc. <i>(Specify)</i>	, farm, str	eet, factory, office		28f	Location (5 City or Tox			Rural Route Nui	mber,
_	o the Hospital or Attending P ithin 24 hours after death.  o the Funeral Director: After t ompletely filled in by the funeral		29a. Certifier 1 🔀 Certifying P	hysician: To the bes	t of my knowled	dge, death	n occurred at the tim	ne, date and	d place, and	d due to the	cause(s)	and manner a	s stated	
	To the Hos within 24 ho To the Fun completely f	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination	and/or in	vestigation, in my op	pinion, deat	th occurred	at the time,	date and	d place, and du	e to the cause	(s)
	To the comp	Ž	29b. Signature and title of certifier	0.			29c. License					e signed (Mon		
	,		Jehore	Ke M	ID.		D52	861		I	lay :	7, 2007		
_	6		30. Name and address of person who Asha Vali	, M.D.			Print) a Avenue,	#342	, Sil	ver Sp	oring	g, MD 2	0902	
Ç.	Sta Registr	te ar	31. Date filed (Month Pay, Year) MAY 0 9 2	007 32. Pigist	trar's Signature		asti I							
						100								

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Philora 3:40 a M Antoine 6, May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗙 F 218-59-9131 Director 82 Aug. 28, 1924 Haiti Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County show 10d. Inside City Limits "natural", or items 23a or 28a-f shov idir al Examiner must be notified at 1 ☐ Yes 2 Tx No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14407 Innsbruck Court 20906 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ SpecifBlack 3 ₩ Widowed 4 Divorced er than "natura", the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Tailoring injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental H is marked Matador Antoine Viergina Paien ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traum Gregory Cherubin/Grandson 14407 Innsbruck Court, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 14 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd, W, Silver Spring, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lung Metastasis Due to (or as a consequence of) death certificate be executed as the burial-transi Exami Breast Cancer and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 certificate 1☐ Yes 1 ☐ Yes 2 🗆 No 2C No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: After

funeral within 24 hours after death.

To the Funeral Director: / completely filled in by the f To the

3

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Tayag, M.D.

<sup>Year)</sup> 9

6 Could not be determined

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

m)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 Yes

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

d63579

2 No

May 7, 2007

1500 Forest Glen Road, Silver Spring, MD 20901

and manner stated.

51.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		i	1 - For State Registrar/AMEND#17, perF				irtment of He tificate of D			ene (	)7	16733
	Physici		Decedent's Name (First, Middle, La  Peter			nselmo			2. Date of Death Month		Year	3. Time of Death 5:30 p <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institution, given	re street and number)			4b. City, Town, or	Location of Death	, .	4c. County	of Death	
			Friends House				Sandy	Spring		Mont	gomery	,
	Funeral			Sex 7. Ago	e (fn yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign try)
	Director		128-03-6047 Usual Residence of Decedent		87				May 27,	1919	New	York
	ahow		10a. State 10b. County		10c. City, 7	Town or Loc	cation				11	0d. Inside City Limits
	he Ma	Director	Maryland Montgome  10e. Street and Number	ery			Sandy Sp	ring				1 ☐ Yes 2 🗷 No
	with I	i Dir	17401 Norwood Road				10f. Zip Code		10	g. Citizen of		try?
	death	nera	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-	14. Rac	J.S.A. e - Americ	
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Mcdical Examiner must be notified at	by Funeral	1 Never Married 2 Married	Armed Forces?  1 X Yes 2 N  If Yes, Give			Yes, specify Cubar  ☐ Yes 2 No	Specify:	Rican, etc.)	Specif	ck, White, e	etc.
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212	ad with	Som	Elementary/Secondary (0-12)	College (1-4or 5	+)	С	ement Mason			Constru	ction	
nd	be file Ital Hy od oth	Be	17. Father's Name (First, Middle, Last	Doloro Ar	~~[~~			18. Mother's Name	e (First, Middle, Ma	a <i>iden Suman</i>	ne) UKN	
aryland 21215-0036	hould d Mer marke	ဥ	Charles Anselmo  19a. Informant's Name/Relationship (			10h Mailin	Address (Street a	Theres		City of Tour	Ctata 7:-	Code
≥	nd 2 salth ar alth ar 27 is		Irene Spurge - Daug				ast Portia			,	State, Zip	C00e)
ore,	es 1 a of Hecol Hecol		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □		20b. Plac	e of Dispos	ition (Name of atory or other place			Oc. Location -	City or To	wn, State
altimore,	ment of I		*4 □ Donation 5 □ Other (Special				ven Cemeter		2007 5	Silver S	pring,	Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic evant, the Mcdical Examinar must be notified at once.		21. Signature of Funeral Service Lice	Clobed		Hi	Name and Address nes-Rinaldi 800 New Ham	Funeral Ho	ome, Inc. nue. Silver	Spring	. Marv	1and 20904
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.							Approximate Interval Between
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l,		Jer	Sequentially list conditions, cause. Enter Underlying	b. Chia to for as a	nonsequer	see off:						
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
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68760	ficate phy s the	edicai		d								
ŏ	death certi e attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy		Ectopic pregnancy			23d. Dai	te of delive	ry
O.	0 00	sicie	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown			Other (specify)	<u> </u>		Мо	nth	Day Year
٦.	s that the de ned by the s a detached t	h)	Part II. Other significant conditions	ontributing to death bu	ıt not resultir	na in the un	derlying cause giver	in Part I	23e. Did toba	cco use cont	ribute to the	e cause of death?
rds	quires n sign uld be	d by	Congestive Heart E				,					ably 4 Unknown
Records,	law requires that the as been signed by th 2 should be detache	Completed	Coronary Artery Di	.sease					24a. Was an	24b. \	Were autop	sy findings available
Ĕ	The ete h page	E O	Renal Failure						autopsy performe 1 Yes 2	ed? c	prior to com death? I 🔲 Yes ::	npletion of cause of 2□ No
Vita	ë ∯ 5	Be	25. Was case referred to medical examiner?	Hospital				26. Place of Death	(Check only one)	-3.000.01-0-		
o	Phys this ral di	2	1 ☐ Yes 2 🔀 No 27. Manner of Death		nt 2 ER	Outpatient b. Time of		4 X Nursing Hor	ne 5 Residence 28d. Describe how			)
on	Attanding I or death. actor: After by the funer	ation	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year)	Injury	28c. Injury : Work? M 1Yo	n es 2 □No	20001100 11011	injury occur.	60	
Division	r Attandi ter death. iractor: A iractor: A	Certification:	3 Suicide 6 Could not b	28e. Place of Inju	ry - At home	, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,		er or Rural	Route Number,
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	To the Hospital within 24 hours a within 24 hours a To tha Funaral Completely filled in the comp	edicai	29a. Certifier 1 □ Certifying Ph (Check only one) 2 □ Medical Exam	ysician: To the best on niner: On the basis of and manner state	examination	dge, death and/or inve	occurred at the time estigation, in my opi	n, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and ma e and place, a	inner as sta and due to	ated. the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	2 un			29c. License	number	290	l. Date signed	d (Month, E	Day, Year)
	5		30 Name and address of severe	nompleted asset of	ath (h	20) (7:	D3474	0		May 7,	2007	
			30. Name and address of person who Robert P. Fields, I	I.D., 18109 P				. Olnev. Ma	arvland 208	332		
	Sta	e ir	31. Date filed (Month Pay, Year) 9	2007 32. Reistra				, 02110/9 116	aryrana 200			
				400	700	100	The same of the sa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 11:45 Agnes Elizabeth Abell 2007 May 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bayside Care Center Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F 214-74-8093 85 Director June 24,1921 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44276 St. Andrews Church Road Funeral 20619 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Who If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or ite Injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes ZHNo þ Specify: 3XXVidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker OWn Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis C. Morgan ဂ Mammie Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Goldsborough / Daughter 43137 Goldsborough Place, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iten
any Injury or oth 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Charles Memorial Gardens May 15, 2007 Leonardtown, Maryland 21. Signatur of Funeral Service Licensee 22 Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Deal Do not enter the mode of wing, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ② No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: 1 ☐ Inpatient 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 17 Rev 1/2001

State Registrar

To the

(Check only one)

James P.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Jarboe, M.D.

2/4035 Three Notch Road, Hollywood, Maryland 20636

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Month Janie Lou Brewer 2007 7:20 Pm May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville f Under 1 Year | If Under 24 Hrs. Casey House Montgomery Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F 229-26-8773 93 Director 4-26-1914 Mississippi Usual Residence of Decedent with the Maryland 10c. City, Town or Location show 10a. State 10d. Inside City Limits r 28a-f show notified at Yes 2 □ No Director MD Mongtomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 603 Sligo Ave Apt. #307 20910 United States death 1 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No **Black** Baltimore, Maryland 21215-0036 ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Domestic and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Willie Brewer Iola Britton ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Rose Coehins (Niece) 6525 Adak Street Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/9/2007 Brentwood, MD 21. Signature of Funeral Service Picensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MN 20722 Letray non -23a. Part1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) been signed by the should be detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed this certificate 1□ Yes 2☑No Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural
2 Accident (Month, Day Year) Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aff 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0001601 5/4/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank C Blackburn, MD 5454 Wisconsin Ave. NW Chevy Chase, MD 20815 31. Date filed (Month, Day, Year)

State

MAY 0 8 2007

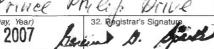


Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 29, 2007 Year **Physician** Charles L. Bell 0700 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery Olnev rs. last birthday) 8. Date of Birth (Month, Day, Y August 23, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 265-56-7549 1**∑**M 2□F Director Florida Usual Residence of Decedent a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Cheverly Yes 2□No Prince George's Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20785 2701 Crest Avenue items 23a "natural", or Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23 Lry or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Chief Warrant Officer (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Bell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 222 Hyattsville, Maryland 20781 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any Injury or other trau once. Laura E. Woodland (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 MBurial 2 MCremation 3 ☐ Removal from State Arlington National Cemetery July 5, 2007 Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** phia fugecc resulting in death) /Medical Due to or as a con uence of): uned tension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine death certificate be executed Cypo Huje and Que to (or as a consequence of): burialattending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9☐Unknown 9 □ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No 24a. Was an has autopsy page perform this certificate 2 XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 7 within 24 hours after deau..

To the Funeral Director; After th 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0059414

State Registrar 31. Date filed (Month, Day, Year)
MAY 0 8 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

They MD 20832 Dr. RAKHMANIN

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Francis Hooper Bond Mar F006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death E ASTON MEMORIAL ALBO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-24-1928 5. Social Security Number Birthplace (State or Foreign Months Baltimore, **X** M 2 □ F Davs Hours 213-22-6557 78 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Talbot Claiborne 1 □ Yes Ž□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21624 USA 23274 Maple Hall Road 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Army Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal 12 years vears Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis M. Bond Katherine Hooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23274 Maple Hall Rd., Claiborne, Md.21624 Rosalie M. Bond (wife) 20b. Place of Disposition (Name of cemetary, crematory or other place) Capitol Crematory 5-3-2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Dover, De. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee R. Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERKALEMIA Due to (or as a consequence of): RENAL FAILVICE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHRONIC OBSTRUCTIVE PULMINARY DISEASE IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

Md

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Department of Health and Mental Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event, tt once,

Pages 1 and 2 should be nent of Health and Mental

or )

Baltimore, Maryland 21215-0036

BOND

death certificate be executed ician and burial-tran as jo ed by the a Physician: The law

P.O. Box 68760

Division or Vital Records,

page 2 should funeral director this Hospital or Attending death. within 24 hours after deatl To the Funeral Director; filled in by the

Physician/Medical Examiner Completed by Be Certification: To

ao+va

State Registrar

completely

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hubritm D0059487

- 007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Botsis, MD Washington St., Easton, Md.

STAN

219 S. Was

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 6:17 A M 2007 Dorothy Ann Barber-Lowe May 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 TF Director 215-34-3067 68 08/11/1938 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than any Injury or other that may Injury or other that mate avent, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 XNo Director Maryland St. Mary's California 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 45249 Andy Way 20619 United States Funeral Race - American Indian Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill lealth and Mental H Be Francis Barber Catherine Whalen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) William Henry Lowe, Sr./ Husband 45249 Andy Way, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdn 5-19-2007 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dysrhythmia minutes /Medical Due to (or as a consequence of Examiner minutes poxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of Examiner physician and s the burial-trans Due to (or as a consequence of): Divísion or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death prothy Ann Barber- howe ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by dependent 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12, 2007 D0064519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) conardtown 20050

State Registrar

DHMH 17 Rev 1/2001

McGovern

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Year)

31. Date filed (Month, Day,

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32. Registrar's Signature

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	/Medic Examin		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, To	own, or L	ocation o		1100		c. County	<u> </u>	4
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	Funeral			6. Sex 1 □ M 2 □ F	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Month,	Day Yes	011	9. Birth	place (State or Foreign ptry) hington, DC
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Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition  1		State	Place of Dispo cemetery, crem .nity M	natory or oth	er place,		M	ay 007		Location - (		
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the xaminer: On the ba	asis of examina	owledge, death ation and/or in	n occurred at vestigation, in	the time	, date and nion, deat	d place, a th occurre	nd due to the	ne cause( ie, date a	s) and mar	ner as s	tated. o the cause(s)
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	Registr		MAY 1 4 2007	(Anna)											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>007</u> **Physician** 12:00 William Ray Boggs, Sr. May 14, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Months 217-36-6056 Director August 19,1936 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10g. Citizen of What Country? 25427 Joseph Way 20636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 Yes 2**XX**No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any injury or other traumatic event, the 1 once. 12 Commercial Sales Propane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lona Bell Chapman P Andrew Jackson Boggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Boggs / Wife 25427 Joseph Way, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery May 17, 2007 Hollywood, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signaturie of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the diseas shock, or heart failure. or complications that caused the ist only one cause on each line ons that caused the lear Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CHF **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CVA Physician/Medical IF FEMALE: if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 □ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed After t after death within 24 hours at To the Funeral D

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To

4 Homicide 29a. Certifier

Medical

3 ☐ Suicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🖎 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

47066

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Mary's Medical Arts Building, Leonardtown, Maryland 20650 A.D. Shah, M.D.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year) MAY 1 6 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#18perFH FCHD, KS 5/18/97/ificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death **Physician** JOHN DIVOK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner HOSSOWN If Under 1 Year | If Linday Woshinsten WOS HINE COUNTRY 10500 If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 XM 2 □ F 235-96-8535 48 Director April 9, 1959 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 □ No Walkersville Directo Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 9946 Kelly Road U.S.A. Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Specify: White 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beekeepers Dispacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Ann Dillon Dillow Benjamin M. Barr, Sr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth J. Barr - Sister 11471 Rothbury Square, Fairfax, Virginia altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Ĉ☐ Cremation 3 Removal from State Metropolitan Crematorium 5/10/07 Alexandria, Virginia 4 □ Denation 5 □ Other (Specify) 21. Signa ure of uneral Service Licen Molesworth-Williams P.A., Funeral Home Muam. 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or pu Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequi-**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and use as the burial-trai Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ρ Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 Tyes 2 TNo 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 2 No 3 Probably Were autopsy findings available prior to completion of cause of 4a. Was an page 2 prior to comp death? 1 🗆 Yes 2 certificate 1□ Yes Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No

Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred I or Attending Fafter death. (Month, Day Year) Division Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed Month, Day Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type,

Registrar

State

31. Date filed (Month, Day, Year)

10

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8 2007 May Schwartz Breeden Virginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 5162 Tiverton Court Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🛛 F 12, Sept. 64 Washington, DC Director 108-34-0432 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5162 Tiverton Court 21703 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? f Med Forces? I ∐Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☒ No "natural", or Baltimore, Maryland 21215-0036 Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Tax Preparer of Health and Mental Hyg item 27 is marked other r other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Deen Schwartz Mary Kampmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other tr Lawrence G. Breeden / Son 4808 Clarendon Drive Frederick, Maryland 21803 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 15, May 15 2007 1 Burial 2 □ Cremation 3 □ Removal from State Cherry Valley, New York 4 □ Donation 5 □ Other (Specify) Cherry Valley Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 Years **Physician** Lung Cancer /Medical **Examiner** Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical Completed by

within 24 hours area....
To the Funeral Director: Aff

Be

Certification: To

Medical

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed c

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Testing in dealing	Due to (or as a conseq	uence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unique of injury	bDue to (or as a conseq	uence of):			
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c 9 □ Unknown	il death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	g cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☒ No
25. Was case referred to medical			26. Place of De	eath Check onl one	
examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1   Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☒ Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not determined		ome, farm, street, fact fy)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1	Physician: To the best of my kno aminer: On the basis of examination	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

May 9, 2007

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar		of Maryl	and / De	partmen <i>ertificat</i>			and M		Reg. No.	07	15	743
	Physici		1. Decedent's Name (First, Middle Charles Daniel								2. Date of De Month May 5,	Day	Year	3. Time o	of Death  A M
	/Medio		4a. Facility Name (If not institution		um <i>ber)</i>		4b. City,	Town, or	Location of		inay 3,		y of Death	0.43	A
			Homewood at					deri		2111			lerick		
	Funeral Director		5. Social Security Number 214-10-1226	6. Sex <b>X</b> ☐ M 2 ☐ F	7. Age (In )	yrs. last birthda Yrs.	Months		If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year) 2, 1916	9. Birthp Coun Mary	lace (State stry)	or Foreign
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<b>5</b>	ital Hygie d other i	Be	17. Father's Name (First, Middle, Daniel Grayson		,						(First, Middle	, Maiden Suma	me)		
_	should be and Mental to marked o	2	19a. Informant's Name/Relations			19h Ma	ailing Address	-				Br, City or Town	State Zin	Code)	
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ore,			20a. Method of Disposition  1   ■ Burial 2 □ Cremation		State	<ul> <li>b. Place of Dis cemetery, c</li> </ul>	sposition (Nan rematory or o	ne of ther place	в)	С	ate	20c. Location	- City or To	wn, State	
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g	Depa impo eny i		21. Signature of Funeral Service	3 m 100	///	11 0	22. Name an			DL		Funeral derick,			21702
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OI VIIA	this ce	၉	examiner?			2 ER/Outpat			4 ∐ Nu			dence 620tl		Arsist.	ALIVIA
Sion	th. After funer	Certification;	27. Manner of Death Natural 5 Pendin 2 Accident investig	9	e of Injury nth, Day Yea	r) 28b. Time	of 2 V M	8c. Injury Work 1 □ Y	at :? ∕es 2 ∐ i		28d. Describe	now injury occur	rred		/
5 3	er dea rector by the	tifica	3 Suicide 6 Could r	not be 28e. Plac	e of Injury - A	At home, farm,					28f. Location (	Street and Num	ber or Rurai	l Route Nur	n <i>ber</i> ,
5 3	urs afte										,				
1	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier Certifyin (Check only one)  2 Medical	g Physician: To th Examiner: On the l and mar	e best of my basis of exam nner stated.	Knowledge, de nination and/or	ath occurred investigation,	at the time in my op	e, date and pinion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(	s)
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	Examir	er	4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Death						
	Eupovol		18003 Horsehead Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Brandyv If Under 1 Year		8. Date of Birth		Prince Georges  9. Birthplace (State or Foreign					
	Funeral Director		326-60-4641 1□ M 2X F 67 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) June 17	1939	Poland					
	D J		Usual Residence of Decedent										
21215-0036	s 1 and 2 should be filled within 72 hours after death with the Marylend if Healith and Menlart Hygiens. If the 71 is marked other than "natural," or Items 23a or 28e-1 show other treumatic event, the Medical Examinat must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔣 No										
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				'	U.S.	•							
		era	18003 Horsehead Road           11. Marital Status         12. Was Decedent Ever in U.S.         13.	20613 Was Decedent of H If Yes, specify Cuba		14. Ra	ce - American Indian,						
		Fur	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	an, Mexican, Puerto Specify:	o Rican, etc.)  Black, White, etc.  Specify: White								
		To Be Completed by	3 Widowed 4 Divorced Year or Dates:		Specil	y: WILLE							
5			15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry										
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lar	2 short and ls ma		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street	and Number or Rui	ral Route Number	City or Town	, State, Zip Code)					
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Baltimore,	int of H		1 🗆 Burial 2 🛣 remation 3 🗆 Removal from State		36			_					
	permit. Pages of Department of Importent: If Ite any Injury or of Once.			Crematory  2. Name and Address		5 <b>,2007</b> untcast1		ity, VA					
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			resulting in death)  Due to (or as a consequent of):	Fack	60/								
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Вох	eath c attend for us	slan	23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth 2 Fetal death 3   4 Pregnant at time of death 5			Date of delivery  Month Day Year							
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Vital Records,	The ate h page			24a. Was a autops		Were autopsy findings available prior to completion of cause of							
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Vita	Physicien: The this certificate ral director, pag		25. Was case referred to medical examiner?	Oth		th (Check only on	1						
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ivision	Attending I r death. ector: After by the funer	tlon	27. Manual of Death 28a. Date of Injury 1 Natural 5 Pending 2 Accident Investigation 28b. Time of Injury at Work? 1 Natural 5 Pending 1 Natural 5 Pending 28c. Injury at Work? 1 Yes 2 No										
	Attendii or death. ector: A by the fu	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		cation (Street and Number or Rural Route Number,								
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certi	4 Homicide building, etc. (Specify)										
			29a. Certifier  (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as tated.										
			one) and manner stated.  29b Signature and title of certifier 29d. Date signed (Month, Day, Year)										
}			( DOW )		6370		4/3	39/2007					
			30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	- /-		( /	,					
Dr. Anthony Thomas 1328 Southern Ave., S.E., #301, Washington, DC								20032					
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 3 2007  32. Begistrar's Signature	all's									
	negistr	aı	MHI O COOL JOSEPH SAL	THE SECOND SECON									

#3,4a,10e,24a,26,206.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death nav Month **Physician** 7:20 A M 2007 James L. Compton May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 46 Davis Rd. Street Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F Feb. 18,1905 NC Director 102 578-46-8975 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1X Yes 2 No DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6007 North Dakota Ave. NW 20011 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 9 3 Nidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Elder Religion 1 and 2 should be filed w Health and Mental Hygies om 27 Is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth M. Henry James G. Compton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra James Allen Compton/Son 13413 Montvale Dr., Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. May 5,2007 | Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident (Stroke) days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending phy d for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by to detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Colon Cancer 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2🔽 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify Caregiver Res 1 Tyes 20 No မ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No thours after death. death. 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C To the Hospital 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certi 29c. License numbe 29d. Date signed (Month, Day, Year) D51208

CR (6)

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark D. Duncan, M.D., 31. Date filed (Month, Day, Year)

MAY 0 8 2007

DHMH 17 Rev 1/2001

600 North Wolfe Street, Baltimore, MD

DHMH 17 Rev 1/2001

State Registrar strar's Signature

	1 - For Stat Reg	te jistrar	State of	Marylan		artmen ertificat			nd Me		giene Reg. No	)7	16747
Physician		dent's Name (First, Middle,	Last)						2	Date of Dea	Day / O	Year	3. Time of Death
/Medica	R		ington Cu			T a.				Mar	1 43	007	1339 4
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Funeral	-			Age (In yrs.		) If Under	1 Year	If Under 2		Date of Birt (Month, Day	0	9. Birth	place (State or Foreign
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and *	Usual Re	te 10b. County		10c. Cit	y, Town or L	ocation							10d. Inside City Limits
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with the Marylar s or 28e-1 ehow	10e. Stre	et and Number				10f. Zip	Code				10g. Citizen of W	/hat Cou	ntry?
23a will will be a 123a	17	1748 East Tedious Creek Road				21672					USA		
S / with the state of the state	11. Marit	11. Marital Status  1 □ Never Married 2 【★Married 12. Was Decedent Ever in U Armed Forces? 1 【★Yes 2 □ No			<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>					14. Race Blac	- Americ k, White,	can Indian, etc.	
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Completed		15. Decedent' (Specify only highest			16a. Dece	edent's Usu	al Occupation	on ring most o	of working		16b. Kind of Bu	siness/In	dustry
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Si (e, N		ther Jane Cus	sick w	ife	1748			s Cre	eek R		ddville		
Doron of the Figure 1	1 🗵	Burial 2 Cremation   Donation 5 Other (Sp		ate C	emetery, cre yland	ematory or o	ther place)	om F			Hurlocl		
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Box 66 eath certific eath certific loruse as	IF FEMA 23b. Wa	is decedent pregnant	23c. If yes, outco	me of pregna		□Ectopic p	ednan cv				23d. Date		
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හ ම ලිලි <u>ව</u>	7				•								oably 4 Unknown
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Dital of purs of illed in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Division of Vital Re To the Hospital or Attending Physician: The Justine 24 hours effer death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	(Ch	16CK OHIY 2 Medical E	xaminer: On the bas and manne	is of examina	ition and/or i	nvestigation	at the time, , in my opin	ion, death	place, and occurred	at the time,	cause(s) and mai date and place, a	ner as s nd due to	itated. o the cause(s)
To the To the To the Comple		nature and title of certifier	1 Some			290	. License n	umber			29d. Date signed	(Month,	Day, Year)
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		e and address of person w			n 23a) (Type	, Print)			0	MA	2161;	7	
State		filed (Month, Day, Year)	200 32. Reg			A.	Q.	100		1 7			
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	For State Registrar	State of Maryland / Department of Maryland / D		Mental Hygi	ene	16748				
	Hegistrar     Decedent's Name (First, Middle, Last		tilicate of Death	2. Date of Death	g. Nó 0 0 1	3. Time of Death				
Physician /Medical	Chaney Rebecca C	hristopher		May 4,	2007	12:55P <sup>M</sup>				
Examiner	4a. Facility Name (If not institution, give	·	4b. City, Town, or Location of Dear	h	4c. County of Death					
	310 Nathans Avenue		Cambridge			Dorchester				
Funeral Director	250-24-2926	x	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min	8. Date of Birth (Month, Day, May 13,	Year) 9. Birthp Cour 1918 Virg	lace (State or Foreign http) Sinia				
aryland show	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits				
to 28a-1 show to 28a-1 show the motified at Director	Maryland Dorchester Cambridge  109. Street and Number 109. Citizen of What C									
3 a or	310 Nathans Avenu	ue	21613		USA					
ulter death v	11. Marital Status	12 Was Decedent Ever in LLS 13	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Americ					
1215-0036 (L. C. within 72 hours after death with the Maryland within "natural"; or items 23s or 28s-f show he Medical Examination must be notified at ompleted by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No	1 □ Yes 2 X No Specify:	to Hican, etc.)	Bfack, White,  Specify: Whi					
72 ho n 72 ho n atur	15. Decedent's Edu	ucation 16a. Dece	dent's Usual Occupation	1	6b. Kind of Business/Inc	dustry				
laryland 21215-00 2 should be filed within 72 hou and Mental Hygiene. Is marked other than "natura" sumatic event, the Medical E	(Specify only highest grad	Colfege (1-4or 5+)	kind of work done during most of wo DO NOT use retired) iness Owner	rking	Grocery					
be filed d other went, III	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, M	laiden Sumame)					
ylano ouid be Mental Marked o maric eve	Zack Tonker		Morry	Jane Svbe						
Though Mark	19a. Informant's Name/Relationship (T)	vpe, Print) 19b, Mailin								
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours att operation of Health and Mental Hygiene.  Apportant: If I tem 27 is marked other than "naturel; or my injury or other traumatic event, the Medical Exercitance.  To Be Completed by F	Howard Christopher/Son 919 Roslyn Ave., Cambridge, MD 21613									
Pages nent of the lift of the	20a. Method of Disposition  1 Aburial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City or Town, State  20d. Place of Disposition (Name of cemetery, crematory or other place)  Dorchester Memorial Park 5/8/2007 Cambridge MD									
Baltimo	21. Signifure of Funeral Sylves Licensee  22. Name and Address of Facility Funeral Home 21613 <sup>A</sup> .  23. Name and Address of Facility Funeral Home 21613 <sup>A</sup> .  24. Name and Address of Facility Funeral Home 21613 <sup>A</sup> .									
	23a. Part1. Enter the disease, or compi shock, or heart failure. List only o	fications that caused the death. Do not en		c or respiratory arre	st,	Approximate Interval Between				
Physician	Immediate Cause (Final disease or condition		Onset and Death							
/Medical	resulting in death)	a. TVNW Cell  Due to (or as a consequence of):	carcinoma							
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687 tiflicate g physical as the black		d								
Geath certification of for use a control of for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	23d. Date of delivery Month Day Year				
igned by the be detached		entributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	Did tobacco use contribute to the cause of dea					
v requir		1 ☐ Yes				2 No 3 Probably 4 Unknown				
	= =====================================			autopsy perform	sy prior to completion of cause of					
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of Vi	1 ☐ Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home   State   Residence 6   Other (Specify)								
June Afte fune	27. Mapner of □eath  Natural 5 □ Pending  2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o	28d. Describe how injury occurred							
i paga	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
the Hospital thin 24 hours to the Funeral impletely filled	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	rsician: To the best of my knowled e. deat iner: On the basis of examination and/or in	h occurred at the time, date and lac vestigation, in my opinion, death occ	a and due to the car urred at the time, da	te and place, and due to	ation the cause(s)				
To the within 2 To the complet	29b. Signature and title of pertition	and manner stated.	20a Lianggo gumbas	.10	d Data signed (Manth					
F.18 5 8	· and In	anno	0006182	7	05/04/	2007				
	30. Name and address of erson who co	ompleted cause of death (Item 23a) (Type,	Byrn St.	Cambrio	lge, mo	21613				
State Registrar	31. Date filed (Month, Day, Year)  MAY 0 7 20	32. Sgistrar's Signature	fools							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 05 Day **Physician** DTANNA ELLIFRITZ 13 2007 1520 J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS - BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 20XF Director 235-72-1024 60 Nov. 18,1946 Keyser, WV Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural', or Items 23a or 28a-f show dical Ex-miner must be notified at 1 ☐ Yes 2 ▼No Director WV Mineral Keyser 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 268 Spruce Drive Funeral 26726 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Hygiene. other than "natura rent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hospital h and Mental Hygie nursing assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Hugh C. Rembold Elizabeth Poland 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Todd Ellifritz/son 268 Spruce Drive Keyser, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√Burial 2 □Cremation 3 □Removal from State 4□Donation 5 □Other (Specify) May 18 Oueens Point Cemetery 2007 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARCINOMA Immediate Cause (Final LUNG 2000 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month detached for 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 171 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 □ No 1 ☐ Yes 2 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ₱1npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only one)

30. Name and a

29b. Signature and the of certifier

DHMH 17 Rev 1/2001

rof person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Iry or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

> **Physician** /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran attending pl signed to this certificate I

Division or Vital Records, P.O. Box 68760,

permit. Page Department o Important: If any injury or once, 21. Signature of Fureral Service Licenses 22. Name and Address of Facility 23a wart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse tuence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 X ER/Outpatient 3 ☐ DOA <sup>2</sup> 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral [ Hospital 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 61707 completed cause of death (Item 23a) (Type, Print) AVE, SUITE 270, TAKOUNT PARK, MD 20912 Sung\_Kim, MD 7660

32. Registrar's Signatu

1XYes 2 No Prince George Hyattsville MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20783 839 Berkshire Drive #1 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 🏋 Married Specify: Black 1 ☐ Yes 🎾 No Specify. <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Apartment Building Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Evans Fate Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nora Evans/Wife 839 Berkshire Dr.#1 Hyattsville,Md.20783 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cheltenham Vet.Cem05/21/2007Cheltenham,Md. Dunn & Sons 5635 Eads St, N.E. 20019 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NAY 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03647 State of Maryland / Department of Health and Mental Hygiene Dennis Patrick Fitzgerald Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 12, 2007 1708 hrs Dennis Patrick Fitzgerald Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 4209 Farragut Street Room 2 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** oreian Hours Months Days VA Country) Director 03/22/1967 218-74-7094 40 1 X M Yrs 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Ob. County 1 X Yes 2 No s 23a or 28a-f show a notified at once. Calvert MD Lusby Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12449 Catalina Drive 20657 USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White etc. ust be Armed Forces? 1 Never Married 2 X Married 2 X Yes Specify: White Yes 2 X No specify: Yes. Give Year Divorced Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed ultimore, MD 21215-0036

nit. Pages 1 and 2 should be filed within 72 hou artment of Health and Mental Hygiene.

sortant: If lieu 27; is marked other than "nation on other transmitive event, the Medical Example 17 yer other transmitive event, the Medical Example. Elementary/Secondary (0-12) College (1-4 or 5+) Rockville Fuel & Feed Truck Driver 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Judy Wyrick Dennis John Fitzgerald Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12449 Catalina Drive, Lusby, MD Baltimore, MD Jennifer D. Fitzgerald/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rockville, MD 5/18/07 Rockville Cemetery Donation 5 Other Specify: 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Se Gasch's Funeral Home, PA Hyattsville, MD 20781 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Physician Between Onset and Death Medical Methadone and alcohol intoxication and cocaine use Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED ##2595,27,28a-f, perME, g867, 5/24/07 TT attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ð Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? has No 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one 25. Was case referred to medical Be Other, Residence 6 🗸 Other: Scene examiner? Nursing Home 5 DOA Inpatient 2 FR/Outpatient 3 this No ۲ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death Certification: 1 Yes 2 X No 1 Natural Pending unk death. Director: FNd 5/12/2007 unk Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. e Hospital or At 24 hours after d 6 X Could not be 4209 Farragut St. HYattsville, MD 3 Suicide Home (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Che To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number signature and title of certifie 29b May 13, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 32. Registrar's Signati State Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Samuel Lee Fairbanks 10:27 a.<sup>™</sup> May 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 314 Willis Street Cambridge Dorchester 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Months Days Hours 1X M 2 ☐ F 220-12-0118 Feb. 17,1927 Director 80 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Willis Street 21613 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 'naturel', or 1 ☐ Yes 2 No Specify: Specify: white Š 3 ₩ Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) superintendent city government 1 and 2 should be filed w Health and Mental Hygier sm 27 is marked other th 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 9 George Edward Fairbanks Maggie Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trau Trisha Lemay granddaughter 314 Willis St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 5/8/07 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 10. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** disease or condition resulting in death) OFMARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Vear MA 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, AND HOSPITAL GEORGE DOUTHERN MARYL 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Director 578 110 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director WASHINGTON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 þ Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event, the Mark Injury or other traumatic event injury or other traumatic event injury or other traumatic event injury event event event event event event event event event event event event event event eve 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -84/1 STNW WASH DC 20012 VIRENE 7430 LANGFORD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/2007 SUITLAND LINCOLN MEM. 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Lio pree 22. Name and Address of Facility 30/5-12th ST NO 20017 ICHN T. RHINES FUNERAR HOME Muse 236. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ( Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-t Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after deau...

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 75

Registrar

ASAR

32. Registrar's Signature

31. Date filed (Month, Day, Year) MAY 0 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE FIGURE STATE OF MAINTAIN DEPARTMENT OF Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Ethel Mae Gesterling 9:20P.M 1,2007 /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Towson Baltimore Gilchrist Center for Hospice If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1□M 2XF Months Days Yrs. Director 481-20-8128 Usual Residence of Decedent 82 August 13,1924 Iowa 10a State 10c. City, Town or Location Long Reach show 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f shov edical Examiner must be notified at Director X Yes 2 No Los Angeles Los Angeles CA. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must once. by Funeral 4752 Faculty Avenue 90808 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Early Childhood ED. Mursery School Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Fred Askren Bessie Klingensmith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Shaw / Daughter
20a. Method of Disposition <u> 26735 Caravan Circle Corona, CA. 92883</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Kurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Mem. Park 5/8/07 Cypress, CA. Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael Marzullo Funeral Chapel Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metristatic UNKNOWA monen conce nech /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of): physician sthe burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown cate nas been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 | Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature arts title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 0 58303 3 May 200 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anon imuns an 6701 N Charles or Toward mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Maniford / Do	partment of Health and N	•	•	
			1 - State Registrar C	ertificate of Death	Reg. Nó	2007	16755
ı	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	y Year	3. Time of Death
	/Media	al	JOSEPH KENNETH GREENWELL  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAY 16,2		7:39A M
	Examir	er	6850 LEONARDTOWN RD.	BRYANTOWN	40.	CHARLES	;
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	0 Pirthala	ce (State or Foreign
ь	Director		216-18-5823 <sup>1</sup> X M <sup>2</sup> □ F 89 Yrs.	Months Days Hours Min.	(Month, Day, Year) 5-14-191	8 WASHI	NGTON, DO
Т	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		100	d. Inside City Limits
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	28a-	rect	10e. Street and Number	10f. Zip Code	10g. Cit	izen of What Countr	v?
	h with	by Funeral Director	6850 LEONARDTOWN ROAD	20617		S.A.	,
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36	or It	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2√ No Specify:	Thour, sto.)		
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פ	be filed ntal Hygie ed other	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden	Sumame)	
<u>ya</u>	Ments Ments arked atic e	To	LEWIS HENRY GREENWELL, SR.	MADOLI	V P. WATH	EN	
Maryland	s 1 and 2 should f Health and Mer item 27 la marke other treumatic			iling Address (Street and Number or Run	al Route Number, City o	r Town, State, Zip C	iode)
e) G	s 1 and if Health item 27 other t		ROSE M.LANGLEY-SISTER 685  20a. Method of Disposition 20b. Place of Dis	0 LEONARDTOWN RI			
Baltimore,	Pages nent of H int: If ite iry or of		1 ▼ Burial 2 □ Cremation 3 □ Removal from State cemetery, c	rematory or other place)		ocation - City or Town	n, State
	그 문란를 .			TION CEM. 5-21- 22. Name and Address of Facility	-07 CLII	NTON, MD.	
R	perm Depa Impo any i		m1 / [ MOO413 ( )	RAYMOND FUNERAL	SERVICE,	P.A.	
			23a. Part 1. Enter the disease, or comblications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	LA PLATA, MD. 206 onter the mode of dying, such as cardiac of	or respiratory arrest,	A	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition  CONGESTIVE	HEART TAI	I HOE	li C	nterval Between Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	HEART FA	LUXE		
	Examiner		Sequentially list conditions b. ATHERO-SC	LEROTIC HEAR	T DISE	ASE	
0	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,		
12	be executed ician and burial-transit	xam	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
/60,	ate be executed hysician and he burial-transit	calE					
2	ificate g phys as the		d				
X P P	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□C'.		23d. Date of delivery	
	death	sicia	1 Yes 2 No 4 Pregnant at time of death	I □Ectopic pregnancy i □ Other (s <i>pecify)</i>		Month D	ay Year
J.	at the 1 by th stache	Phys	9 Onknown				
Ś,	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		se contribute to the	
0	requi	eted	DIABETES-TYPE 2		1 Yes 2	No 3 Probab	ily 4 Unknown
ခို	e law has t	Completed	HYPERTENSION		24a. Was an autopsy	24b. Were autops: prior to comp death?	y findings available letion of cause of
Vital Record			PROSTATE CANCER		performed? 1 ☐ Yes 2 No	1 Yes 2	□ No
5	ysicia is certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death		Пон из из	
0	ding Phy h. After this funeral d	<b>:</b> - +	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Residence ( 28d. Describe how injur		
0	ttending death. tor: Aft the fun	atio	i Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
UNISION	er de er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State		Route Number,
2	ital o irs aft rel Di						
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the tuneral director,	Medical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as state place, and due to th	ed. ie cause(s)
	o the ithin 2 o the implei	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number		e signed (Month, Da	
	F ≥ F 8		V. Anwanger	D 26064		5-17-2	
	,		30. Name and address of person who completed cause of death (Item 23a) (Typ.		0 =	- 1 1	
	(a)		V. ANM AN GAND CHARL	OTTE HALL, MD	20622		
	Sta	_	31. Date filed (Month, Day, Year) 3 Registrar's Signature		3		
	Registr	ar	MAY 2 3 2007 Beauty	BACC			

State

Registrar

31. Date filed (Month Day,

9 Year)

2007

gistrar's Signature

			For State	State of Ma	arylan		artment of			ental Hyg	iene		a ,-a cong girin	^
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cei	Tillicate of	Deam		2. Date of Deat	g. No.		3. Time of Death	ä
	Physici		CHARL	ŕ	LMES					Month APRIL	Day	Year 007	1142	Л
	/Medic Examin		4a. Facility Name (If not institution, g		3-12-0		4b. City, Town,	or Location	of Death	232 212 23	4c. County of		<u> </u>	
*	7 .		201 Old M					ithe:					OMERY	
	Funeral			Sex 7. Ag 1 ☐ M 2 🖫 F	e (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, Oct • 19	Year)	9. Birthp	lace (State or Foreig try) SSOUTI	n
	Director		219-64-1667 Usual Residence of Decedent		09					001.19	, 1937	1,1 T ;	SSOULT	
	nyland <b>how</b> lat		10a. State 10b. County MD Mont	COM CIGIT	10c. City	, Town or Lo		- lo	~			1	0d. Inside City Limit	
	ne Ma 8a-f s otiflec	Director		gomery			Gaither	SDUL	9				1. Yes 2 □ N	)
	should be filed within 72 hours after death with the Maryland not Mently Hygiene. rnarked other than "hatural", or items 23a or 28a-f show marked other than "hatural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at		10e. Street and Number 201 Old Ma	cDonald I	Soad		10f. Zip Code	2087	7	10	ng. Citizen of W	hat Coun S . A		
	ms 23	Funeral	11. Marital Status	12 Was Decedent	Ever in U.S	S. 13.	Was Decedent of If Yes, specify Cu		-	cify Yes or No-	14. Race			_
o	after or ite		1 □ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 24 I If Yes, Give	No		If Yes, specify Cui 1 □ Yes ※ X□ No			lican, etc.)		, White,	<sub>etc.</sub> Lack	
0000	hours ural", Il Exa	d by	3 Widowed 4 Divorced	Year or Dates:					•		Specify:			
ה ה	in 72 l i "nat ledica	Completed	15. Decedent's (Specify only highest of	rade completed)		16a. Deced (Give life. I	dent's Usual Occu kind of work done DO NOT use retire	ipation e during mos ed)	st of workin	g	16b. Kind of Bus		dustry Mill	
7	d withing siene.	mo	Elementary/Secondary (0-12)	College (1-4or 5 1 yr	5+)		Counse				Hous		мттт	
and,	al Hyg al Hyg I othe	Be C	17. Father's Name (First, Middle, La	,				18. Mothe		(First, Middle, N	faiden Surname	e)		
Ž	ould b Ment Ment arkec	인	Unknow							nown				
Nar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If the Zr is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship  John T. Holme		nd)		ng Address (Stree							
<u>စ</u> ်	Healt Healt tem 2		20a. Method of Disposition	=5 (Husba	20b. Pi	lace of Dispo	sition (Name of		· ·		20c. Location - (			_
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A,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as										
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X D D	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7F.a4:-				23d. Date	of delive	ery	
	e deat he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Ectopic pregnan Other <i>(specify)</i>	Су			Mon	th	Day Year	
7	w requires that the de been signed by the should be detached		9 ☐ Unknown  Part II. Other significant conditions		ut not resu	ulting in the u	nderiving cause a	iven in Part I	1	23e Did toh	acco liee contri	huta to th	ne cause of death?	_
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	Hospit 4 hour Tunera ely fille		(Check only 2 Medical Ex	Physician: To the best aminer: On the basis o	of my know	wledge, deat	h occurred at the	time, date a	ind place, a	nd due to the ca	ause(s) and mar	ner as st	tated.	_
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical	one)  29b. Signature and title of Cartifier	and manner sta	ated.	= +1 111		se number		-				
	Z W Z	_	) / XC	le				57699	9	2:	od. Date signed. May			
	8		30. Name and address of person wh	o completed cause of c	leath (Item	23a) (Type,								_
	v		Gail L. Seik	en, M.D.	4915	Aub		., #	104,	Bethe	sda, Mi	20	814	
	Sta	ite	31. Date filed (Month, Day, Year)	2007 32. Paistr	ar's Signa	ture	1 1							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 200<sup>Year</sup> **Physician** Elva Marie Horst 16 9:55 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mennonite Home Maugansville Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth May 28 1914 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min Maryland 1 □ M 25 □ F 214-32-4893 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits or 28e-f show traumatic event, the Medical Examiner must be notified at MD. Washington Maugansville 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 13436 Maugansville Rd.- P.O. Box 670 21767 U.S.A. Items 23a permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: if item 27 le marked other then "never any injury or other traumation." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housework 8 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Abram G. Horst Susie Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester Horst /Nephew 12589 Hollowell Church Rd. Greencastle Pa. 17225 20b. Place of Disposition (Name of cemetery, crematory or other place)
Millers Mennonite
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5/19/07 Leitersburg, MD. <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licensee arte 45 S. Carlisle St. Greencastle Pa. 17225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ne umoni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 05 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License number MMOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern Ave Shahid 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 3 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Roberta Mae Herd 10:30 a M 2 May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Dorchester 1490 Cambridge Beltway Cambridge If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year Oct. 2, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 ■ M 2 🔀 F 55 1951 Director 215-62-0998 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10h County Items 23a or 28a-f show Examiner must be notifled at Yes 2 No Director MD Dorchester Cambridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number hours after death with 21613 USA 1490 Cambridge Beltway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. altimore, Maryland 21215-0036  $^{\prime\prime}$ 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours afte nent of Health and Mental Hyglene.
Init: If Item 27 Is marked other than "natural"; or I wit if Item 27 Is marked other than "natural"; or I ury or other traumatic event, the Medical Examini ury or other traumatic event, the Medical Examini 1 ☐ Yes 2 🔀 No Specify white Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) licensed practical nurse health care 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Chew Virginia Dunn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trau 1490 Cambridge Beltway, Cambridge, MD Michael T. Herd husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Removal from State 5/5/07 East New Market Cem. East New Market, MD 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Lim Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Varian **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thickering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an s certificate has t lirector, page 2 s autopsy performed? 1□ Yes 21 No To the Hospital or Attending Physician: after death.

Director: After this certific

in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Dath 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 THomicide determined within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOUG1822 May 7th 503 Byrn St. Combridge, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Widmiller 31. Date filed (Month, Day, Year) 32. Regi ar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:00 AM CHARLES WALLACE May 2007 HUGHSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 216 Meteor Ave. Apt. Cambridge Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
F L 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 AM 2 ☐ F 267-26-0341 80 Director Sept.30,1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medic I Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MDDorchester Cambridge 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Meteor Ave. Apt. 902 21613 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Baltimore, Maryland 21215-0036  ${\mathscr U}$ Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify White þ Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Oliver Hughson Mary Hoskin Hughson Gruener 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21613 19a. Informant's Name/Relationship (Type. Print) Sylvia B. Hughson/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cem. 5/8/07 Hurlock, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, PA 216 North Main St. Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic 3 month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed phlmones 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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M.D

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar
18
19a, FH,
Decedent's Name (First, Middle, Last) 19a, FH, TCHD, 05/11/07pha Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** 10:45 PM 05 02 2007 Johnson Mattie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Home Queen annes Hills Nursing Centreville Corsica If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-25-1919 5. Social Security Number 6. Sex **Funeral** 1 M 201 Yrs. N.C. Director 215-22-5416 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir then "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Grasonville Maryland Queen Annes 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13 Grasonville Terrace 21638 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Midowed 4 Divorced black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Seafood Worker Seafood 2 should be filed w and Mental Hygier is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If them 27 is marked c 2 Moody Tabor Hattie Overby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Obey/Son 2391 Kingston Street, Aurora, CO. 80220 Nathaniel Walkins 20b. Place of Disposition (Name of cometery, crematory or other place)
Union Wesley U M
Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 05-12-2007 Chester, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Siggature of Funeral Service Licensee Mumie 426 Dover Street, Easton, Maryland 21601 23a Part. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Styructive **Physician** Chrome disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy WORTH in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Wendation 1 Yes 2 No 3 Probably 4 Unknown Completed Tementic 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Posichard. Vascular 25. Was cas referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: ol or Attending F after death. I Director: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dutchmons (1000len 31. Date filed (Month, Day, Year) egistrar's Signature State 0 8 MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 9:05 AM Johnson eanette 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Care ('aMbride ambr. )orchester enter 90 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 1 2 F Months Days Hours Min. 214-12-5990 Yrs. 1921 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No ambridge 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Stree USA 1613 on 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 PNo If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rivate WOYK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Manokey 19b. Mailing Address (Street and Number or Journal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cambridge, onnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lo stion City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 5 114/07 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Funeral Home, P. A

South Cambridge, MD, 21613

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Cardiac or respiratory arrest,

Approximate

Immediate Cause (First)

**Physician** /Medical Examiner

the Hospital or Attending Physicien: The law requires that the deeth certificate be executed

been signed by the should be detached

s certificete hes b lirector, page 2 sl

within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director.

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Be Completed

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

other

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Examine ettending physicien and for use as the burial-tran

1 - For State Registrar

10a. State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. 27 is marked other then "natural", or items 23s or 28s-f ehow traumatic event, the Medical Examinar must be notified at

Completed by Funeral Director

Be

၉

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant al time of death

in the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

1 Yes

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

1 Yes

2 No

Approximate Interval Between Onset and Death

26. Place of Death Check only one Other. 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred

27. Manner of Death 1 X Natural 2 Accident

3 Suicide

4 | Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 X No

29a. Certifier (Check only one) 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

4) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Aut/16



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APRIL **Physician** 30 200<sup>4</sup>7<sup>ar</sup> **EDWARD** KOHLHEIM 10:08 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 16201 BALD EAGLE SCHOOL ROAD BRANDYWINE If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, AUG 15 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 11XM 2□ F 41 WAŠHINGTON, DC 219-15-4576 Director AUG 1965 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director PRINCE GEORGE'S BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20613 U.S.A 16201 BALD EAGLE SCHOOL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n: any injury or other traumatic event, the Medic once. College (1-4or 5+) 2 YRS Elementary/Secondary (0-12) NONE DISABLED 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MCCOY EDWARD LEON KOHLHEIM **ELLA** ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16201 BALD EAGLE SCHOOL ROAD BRANDYWINE, MARYLAND
20613 19a. Informant's Name/Relationship (Type. Print) EDWARD LEON KOHLHEIM/FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) RESURRECTION CEMETERY 5/5/2007 CLINTON, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AQUIRED IMMUNODEFIEIENCY DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to himbolist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the agreence extra a formation of law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 s has autopsy certificate 1□ Yes 1 ☐ Yes 2 ☑ No 2X No Physiclan: director 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 2 D52798 MAY 4, 2007 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 7525 GREENWAY CENTER DRIVE SUITE 202 GREENBELT, MARYLAMD 20770 DIVYA VERMA M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 8 2007 Registrar

07-03695 Wa

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ilter Dale h	Kesn	1-	For State Of Waryland / Department of Health and Waryland / Department of Health / Department of	Reg. N	o	3. Time of Death
Phys	sicia		Decedent's Name (First, Middle,Last)	ate of Death onth Day ay 14, 2007	Year	1020 hrs
	amin	er	Walter D. Resner		4c. County of De	eath
		4	Western Maryland Braddock Campus  4b. City, Town, or Location of Death  Cumberland		Allegany	
_			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. I	Date of Birth(M		Birthplace (State or reign
Fune Direc		1	234-64-3254 1XM 2 F 65 Yrs. Months Days Hours Min.	1/16/	42	Country) WV
			Jsual Residence of Decedent  10c. City, Town or Location			10d. Inside City Limits
	w any		WV Mineral Keyser			1 Yes 2 X No
faryland	- Sno	후	10e. Street and Number	10g. (	Citizen of What	Country?
e Mary	or 28a-1 sno fied at once.	Director	RT. 6 Box 6170 26726	1	U.S.A.	
vith th	s 23a notil		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify	y Yes or No-	14. Race - A White, e	merican Indian, Black, tc.
eath v	item ust be	Funeral	1 Never Married 2 XMarried 1 Yes 2 X No	, 0.0.,	0	white
after d	ner 111	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work)	done 16	Specify: b. Kind of Busin	
hours	xami		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)			
<b>36</b> in 72	han " dical 1	Completed	Construction			er Plant
-00. 4 with	ther t	틧	18.Mother's Name (First Middle Last)			
21215-0036 ould be filed within 72 hours after death with the Maryland I Mental Hygiene.	ent, th	ക്ല	Walter W. Kesner  Helen G:  19b. Mailing Address (Street and Number or Rura			State Zin Code)
<b>2</b> 8 8 8	tant: If item 27 is marked other than 'or other traumatic event, the Medical	ြို	19a. Informants Hamor Colored	Keyser	, WV 2	6726
E d Z	If item 27 her trauma		20b. Place of Disposition Date of Disposition (Name of cemetery,	ate 2	0c. Location - C	ity or Town, State
Baltimore, permit. Pages 1 ar Department of Hee	If ite		1 Typeurial 2 Cremation 3 Removal from State crematory or other place)	8/07	Mt. St	orm, WV
timent Page	rtant:		4 Donation 5 Other Specify: DISMAIN Communication			- 1
<b>Bal</b> l permit Depar	Important: If i		21 Signature of Futieral Service Licenson	Home,	WV 267	726
	cian		Hark Wood Fuller at P.O. Box 912, Ke 23a. Part I. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or re	spiratory arrest	, shock, or hear	Approximate Interval Between Onset and
Med	iica	8 7	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease			Death
Exam	iner		or condition resulting in death)  Due to (or as a consequence of):			
		ų,	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		jë	If arry, reading to infinite Course			
E KUI	sit	Examine	events resulting in death) Last			
68760, certificate be executed	After this certificate has been signed by the attending physician and fineral director mase 2 should be detached for use as the burial - transit	Sa E	X UNPENDED AMENDEO 27 PORME 0867 5/24/07 TT			- 1 12
<b>60,</b> tte be e	ysicia burial	Physician/Medical	IF FEMALE:  AMENDED #23a,27, perME, g867, 5/24/07 TT  23c. If yes, outcome of pregnancy		23d. Date of	·
876 tificat	ing ph as the	N/ug	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnance past 12 months?	СУ	Month	Day Year
Box 687	attend or use	Sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown			
Records, P.O. Box	by the	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			oute to the cause of death?
P.O	gned be	۵				Probably 4 V Unknown
ds, equire	een si	Completed		24a. Was a autops	y <b>[</b> P	Vere autopsy findings availab rior to completion of cause of
COT	has be 2 sh	1 2		perform 1 🗸 Yes 2		eath? ✓ Yes 2 No
	ificate	၂ ပိ		nly one)		
/ital	iis ceri	Be de	examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing		Residence 6	Other:
Division of Vital Records, P.O.	fter th	Į į	27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?	28d. Describe h	ow injury occurr	ea
on endir	eath. .or: A	j.	1 Natural 5 Pending 1 Yes 2 No large factory office building etc.	20f Location (S	treet and Numb	er or Rural Route Number, Ci
ViSi	ifter de Direct in by	j.	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, S		
Division of Vital	ours a	9		due to the caus	e(s) and manne	r as stated.
he Ho	in 24   he Fu	Completely	2 2a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the line, dut and press, and (Check only) one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at	the time, date	and place, and o	due to the cause(s)
9	To t	Modical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date sign	ed (Month, Day, Year)
		-	O.C.M.E.		May 15, 20	007
			30. Name and address of person who completed cause of death (Item 23a)			
	\$		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	·	Sta	e 31. Date filed (Month, Day, Year) 7 7 32. Registrar's Signature			
	Reg	istra	ar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM 19a per INF. 08/75/29/07 WS
State of Maryland Department of Health and Mental Hygiene

Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 APRIL 30, **Physician** 15:01P M LEWIS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE SOUTHERN MARYLAND HOSPITAL CLINTON, MD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11-15-1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1□M 2 F VIRGINIA 579-76-1924 50 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location r then "naturel", or iteme 23a or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No PRINCE GEORGE DISTRICT HEIGHTS Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 U.S.A. 1848 ADDISON RD SOUTH Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "eny injury or other traumatic event, Ita-Mis gong. College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OLIVER LEWIS SR ETHEL DOUGLAS BROWN 19a. Informant's Name/Relationship (Type, Print)
Stephon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN CHESTER SR/SON 2903 WEST GRV UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-9-2007 SUITLAND, MD LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL **Physician** INFARCTION /Medical Due to (or as a consequence of): Examiner DISEASE CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Onknown HYPERTENSION Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) ၉ 1₽Yes 2□ No 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 1 (D) Natural 28a. Oate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number APRIL 30, 2007 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRAITS ROAD, CLINTON, MARYLAND 20735 TERRY JODRIE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2007 Registrar

State Registrar WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARKIMD

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign dure

ROSS SWITKES

31. Date filed (Month,

MAY 08

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2007 Month MAY **Physician** LEROY MOORE 1302 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S MALCOLM GROW MED CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 1 XM 44 01-28-1963 Director UNKNOWN WASHINGTON, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show notified at FORESTVILLE PRINCE GEORGE Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 2721 LORRING DR #202 20747 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK 2 3 X Widowed 4 ☐ Divorced Completed 1 and 2 should be filed within 72 he Health and Mental Hygiene. em 27 is marked other than "natui other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAROLD B. MOORE SR. DORIS N. PERRY ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 7700 TEMPLE HILL RD TEMPLE HILL, MD 20748 DORETHIA JARVIS/SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 □ Cremation 3 ☐Removal from State RESURRECTION CEMETERY 5-7-2007 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HUMAN IMMUNODEFICIENCY VIRUS INFECTION /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s certificate | 1□ Yes Physiclan: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 XER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? or Attending 5 Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death death filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Floute Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026024 MAY 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LESTER MILES, MD 6490 LANDOVER RD LANDOVER, MD 20785 31. Date filed (Month, Day, Year, 32. Registrar's Signa State

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Registrar

MAY 0 A 2007

		1 - State Registrar	State of Maryland	•	rtment of tificate of			Reg. No	Z 11 11 7	16769
Physi /Mec Exam	lical	Decedent's Name (First, Middle, Last)     Stephen Harold     4a. Facility Name (If not institution, give st.     500 Freeland Ro	reet and number)	:	4b. City, Town, Free		2. Date of I Month May	15 Da	2007 . County of Death	
Funera Directo	_	5. Social Security Number 187-30-0578  Usual Residence of Decedent	7. Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of 8. (Month April	Birth Day, Year <u>)</u> 21	9. Birth Cou Pen	place (State or Foreign intry) nsylvania
e Maryland 3a-f show	Director	MD 10b. County Baltimor	,	Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with th	Dire	10e. Street and Number 500 Freeland R	oad		10f. Zip Code 210	53			tizen of What Cou S • A •	intry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23e or 28e-f show any injury or other traumatic event, it a Modical Examinator resulting at	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:			Hispanic Origi ban, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ameri Black, White, Specify: Wh	, etc.
21215-0036 ad within 72 hours aff giene. er than "natural", or i. It e Madreal Extern	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give life. [	ent's Usual Occupation kind of work done during most of working DO NOT use retired) TMC T				ind of Business/Ir retable	
Maryland  nd 2 should be fite filth and Mental Hy 27 Is marked other rtraumatic evant,	To Be C	17. Father's Name (First, Middle, Last) Albert Samuel M	Miller				's Name (First, Midd nerine M			
Mar ind 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Type Charlotte Gene Mi					or Rural Route Num Freel			
ages 1 and of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRe			sition (Name of natory or other pla om Cemet	1	ay 19,		ocation - City or T	own, State m , PA 17349
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe	XIIKE	21. Signature of Funeral Service Licensee  Mulul 2√ 9		22	. Name and Addr	ess of Facility	007 J.J. Har , New Fr	tens	tein Mor	tuary, Inc.
ds, P.O. Box 68760, An ires that the death certificate be executed by the attending physician and be detached for use as the buriat-transit be detached for use as the buriat-transit.	Ical Examiner	23a. Part1. Enter the disease, or complicing shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseque	nce of):		1 .	1 1	arrest,	ase	Approximate Interval Between Onset and Death
VISION OF VITAI HECORDS, P.O. BOX 68 Attending Physicien: The law requires that the death certifica actor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of pregnand 1  Live birth 2  Fetal d 4  Pregnant at time of dea 9  Unknown	eath 3	Ectopic pregnand Other (specify)	су			23d. Date of deliv Month	rery Day Year
Hecords, P he law requires that e has been signed b age 2 should be deta		Part II. Other significant conditions control	ributing to death but not result	ing in the ur	nderlying cause g	iven in Part I.		tobacco		the cause of death? bably 4 Junknown
Vital Recc icien: The law r certificate has be ector, page 2 sh	Completed						pe 1 ☐ Yes	opsy formed? 2. No	prior to co	opsy findings available ompletion of cause of
DIVISION OT VITAI I or Attending Physicien: T after death. Director: After this certificat d in by the funeral director, p	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		R/Outpatien 8b. Time of Injury	28c. Inju	her: 4 🗆 Nurs	28d. Describ	sidence	6 □Other (Speci ry occurred	fy)
Digital of I	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office			(Street ar own, State	nd Number or Run e)	al Route Number,
To the Hospitel or within 24 hours after To the Funerel Direction	edical (	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination and manner stated.	edge, death in and/or inv	occurred at the trestigation, in my	opinion, death	place, and due to the cocurred at the time	e cause(s e, date an	) and manner as s d place, and due t	stated. to the cause(s)
To th Within To th compl	Me	29b. Signature and title of certifier	Dent		29c. Licen	se number	7	29d. Da	te signed (Month,	Day, Year)
10	(	30. Name and address of person who com	pleted cause of death (Item 2	3a) (Type.	Print)	0441	1) 11	, IQ.	7 14, 20	0 3
	tate trar	PHILICMILITEL  31. Date filed (Month, Day, Year)  MAY 2, 3, 2007	32. Registrar's Signatu	rimbi	e 4:11	CK LK	thenu:11e	1	210	4 )

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16,2007 Month MAY **Physician** 8:45A HARRY RONALD MOODY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11204 CARROLL DR. WALDORF CHARLES If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 217-44-5858 1 XM 2 F Yrs Director 6-6-1944 WASH., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2√2 No MD. CHARLES Directo WALDORF 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11204 CARROLL DRIVE 20601 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) D.C.GOVT 12 ELECTRICIAN Ith and Mental Hygie 27 is marked other if traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f h and Mental h HARRY LADD MOODY EVELYN REBECCA POSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is GLORIA MOODY-SPOUSE 11204 CARROLL DR. WALDORF MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) T] injury or Department Important: If any injury or TRINITY MEM. GARDENS 5-23-07 WALDORF, MD. 21. Signature of Juneral Service Licensee 22. Name and Address of Facility MOO479 RAYMOND FUNERAL SERVICE P.A. the LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, LUNG WITH Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of: Examine rsician and e burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical phys the L attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After t the Hospital or Attending 5 Pending investigation 1 Natural after death. Director; Af 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 To the F 29b. Signature and title of certifier 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) OUD LINE CENTER 12070 NISOTSK 32 Registrar's Signature 31. Date filed (Month, Day, Year) 23 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear **Physician** Beatrice 6:20 AM Adams Mason April 30, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rebecca House Nursing Home Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2/□F Months Days Hours Min. 577-07-0975 95 Director 9-25-1911 Hagerstown, MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h Counts If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 120 Park Avenue United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 2 Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12th Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amos Adams Helen Wagner ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health ar
Important: If item 27 is
any injury or other trau Rodney Mason (son) 1037 Delf Drive McLean, VA 22101 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/5/2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Heart Disease 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? 2 No 1☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 X Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 7 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 1) 060 9317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byrne, 23335 Nash street Arlington, VA 22202 Robert F. MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

32. Registrar's Sign

			1- For State of Maryland / Registrar	Departmen Certificate				giene () ()	7	16772
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Irmgard Malek	-			2. Date of Dea Month May 5,	Day	/ear	3. Time of Death 3:46 PM
	Examir		4a. Facility Name (If not institution, give street and number) National Lutheran Home			ocation of Dea		4c. County of Death Montgomery		
- 24	Funeral Director		5. Social Security Number 0.89 − 26 − 7277 6. Sex 1 □ M 2 □ F 87	oirthday) If Under Yrs. Months	1 Year Days	If Under 24 Hrs Hours Min		, 1919	Coun	lace (State or Foreign try) many
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Ton Md Montgomery	wn or Location Rockvi	11e				1	0d. Inside City Limits 1X1 Yes 2 ☐ No
	th with the 23a or 28s	al Director	10e. Street and Number 9701 - Veirs Drive	10f. Zip		850		-	Citizen of What Country?	
920	hours after death with the Maryland turst', or Items 23a or 28a-f show at Exercitive fourtible dat	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marned  1 □ Never Married 2 □ Marned  1 □ Never Married 2 □ Marned  1 □ Yes, Give Year or Dates:	13. Was Deced			Specify Yes or No- to Rican, etc.)	Black,	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	within 72 iene. then "ne!	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  1 2	a. Decedent's Usua (Give kind of wor life. DO NOT us Milline	rk done du se retired)		orking	16b. Kind of Busi		•
and ?	be filed stal Hyg od othe svant,	Be	17. Father's Name (First, Middle, Last)  Albert Wessels	711 1 1 1 116			me (First, Middle,	Maiden Sumame)		
aryla	2 should be fill and Mental H is marked otlanmatic sysm	70	19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address	(Street an	d Number or A	e Grünh ural Route Numbe	r, City or Town, Si	ate, Zip	Code)
	1 and 1 Health sm 27		1 Burial 2X Cremation 3 Removal from State	of Disposition (Namery, crematory or of	ne of ther place)		Date	20c. Location - C	ity or To	wn, State
Baltimore,	permit. Pages Department of I Important: If Iti sny Injury or o'		4 Donation 5 Other (Specify) Metrop  21. Signature of Funeral Service kicensee	olitan 22. Name an Hysoi	d Address		2222-		sin	Ave.,NW
8760,	Physician /Medical Examiner and physician an	dical Examiner	23a. Part1. Enter the disease, or commiscations that caused the death. Do shock, or heart failure. List only be cause or each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence cause in the cause of the	9 of): 15 9 of): tract i	6		c or respiratory an	rest,	1	Approximate Interval Between Onset and Death weeks
P.O. Box 68	the death certifi y the attending ched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No   9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 9   Unknown   1   Unknown   1   Example 1   1   1   1   1   1   1   1   1   1	h 3 Ectopic pre				23d. Date of Month		ry Day Year
rds, P.	The law requires that that the has been signed by sage 2 should be detact	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying ca	ause given	in Part I.	23e. Did to	bacco use contrib		e cause of death?
al Reco		Completed					24a. Whas a autop: perfor 1 🗆 Yes	sy prid med? dea	or to con ath?	osy findings available inpletion of cause of 2 No
Division of Vital Records,	To the Hospital or Attending Physicien: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	atlon; To Be			Other: 8c. Injury a Work?	4 Nursing I	ath (Check only or Home 5 Resid			)
Divis	ital or Atters as after de al Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory	, office		28f. Location (S City or Town	treet and Number n, State)	or Rurai	Route Number,
	To the Hospital within 24 hours a To the Funeral D completely filled i	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	nd/or investigation,	in my opir	nion, death occ	urred at the time, d	late and place, and	d due to	the cause(s)
	To To con	-	29b. Signature and title of Sertifier  Lennel M. Mulli-		License r	506/2		May 6		
2	(5)		30. Name and address of person who completed cause of death (Item 23a)  Dr. Samuel Maller- 9701-	(Type, Print)				0		1
16	Sta Registr		31. Date filed (Month, Day Year) 32. Registrar's Signature.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 16<sup>Day</sup> Month **Physician** May 2007 James Robert Moorhead 7:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3164 Aldino Road Churchville Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Apr. 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months XXM 2□F 74 Apr. 1933 Pennsylvania 215-34-5613 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3164 Aldino Road 21028 U.S.A. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ant of Health and Mental
t: If Item 27 Is marked o
y or other traumatic eve John Moorhead Mary Geneva Irvin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 MacIntosh Dr. Karen J. Heckman (Daughter) Colora, MD 21917 permit. Pages 1 are Department of Hee Important: If Item any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 5/21/07 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Tarring-Cargo Funeral Home, Aberdeen, Maryland 21001-3 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a cons of ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 TYes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 500 Upper Chesapeake 31. Date filed (Month, Day, 31. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Lucille D. Miles 3:29 AM 05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NMS Healthcare of Hagerstown Hagerstown Washington If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Yrs. Director 191-26-6869 Aug 10, 1910 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Washington Hagerstown 1 ☐Yes 2X1No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 14014 Marsh Pike USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black à Specify. 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Dade Mary Spottswood ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Miles grandson 701 Forest Dr., Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Green Hill Cemetery 05/21/2007 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. of Funeral Service Lic 50 S. Broad St., Waynesboro, PA 17268 23a. Parti. Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** enebral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner in any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iding physician and se as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ⊋Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No P 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D060396 1126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHED ARID Myn

Registrar

32. Registrar's Signature

3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 16 5:40 P M **Physician** 2007 James Vernon Mattingly, Sr. May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth
(Month, Day, Ye
June 4, 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 11X M 2∏ F 92 577-09-6639 1914 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Hollywood St. Mary's Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20636 24054 Rustic Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinatione. 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Food Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clare Mae Wallace James Henry Mattingly, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Grand-13103 Millhaven Place Germantown, MD 20874 Gerald Blair Mattingly Johnson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 21, 2007 Leonardtown, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Gardens 4 Donation 5 Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licenses Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death M I n which S at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury Due to for se a consequence of) iner The law requires that the death certificate be executed Exami that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day for in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1010 MY 0 アンカルフ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform DC AO\_ 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: after death. Director: After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospitai

within 24 hours a Medical (Check only one) 29b. Signature and title

29c. License number D0061719 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhananjay Bhavsar, M.D. 24035 Three Notch Road Hollywood, MD 20636

31. Date filed (Month, Day, Year) State

MAY 1 8 2007



Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death

4b. City, Town, or Location of Death

BETHESDA

2. Date of Death

MAY 8 2007

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

HARVEY IRVING MUELLER

Physician

/Medical

Examiner

3. Time of Death

12:07 P M

9. Birthplace (State or Foreign

10d. Inside City Limits 1 XYes 2 No

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Year

Illinois

Year

MONTGOMERY

4c. County of Death

NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 FARZAD NOWROUZZADEH LT MC

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

01059669A (IN)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

05/03/2007

State Registrar

funeral director,

this

After

within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

Be

Medical Certification: To

25. Was case referred to medical

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

examiner?

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

1-	For State Registrar
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			1 - State Registrar		Cer	tificate of L	Death		R	leg. No.		
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ıth		3. Time of Death
	/sicia ledic		James Mege	e					Month May 8,	Day 20		5:37 AM M
	rearc amin		4a. Facility Name (If not institution, give		T	4b. City, Town, or	Location of	f Death			County of Dea	
			9962 Champ Road			Princess	Anne	:			Somerse	t
Fund	eral		Social Security Number		thday)	If Under 1 Year	If Under 2		B. Date of Birth (Month, Day	1	9. Bir	thplace (State or Foreign
Direc			218-36-9718	<sup>1M 2□ F</sup> 67	Yrs.	Months Days	Hours	Min.	03-02-1			yland
р.			Usual Residence of Decedent  10a. State 10b. County	10.00.7								1
aryla	펼	-	10a. State 10b. County	10c. City, Town	n or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
96 M	4	Sch	Maryland Somerse	t Prin	ces	s Anne						
ith th	8	2	10e. Street and Number			10f. Zip Code			1	10g. <i>C</i> iti	zen of What Co	ountry?
ath v	187	Funeral Director	9962 Champ Road			2185					US	
er de	9	une		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>	
s aft	9	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No 1957 − If Yes, Give Year or Dates: 1959	1	1 □ Yes 2 No	Specify:				Specify:	
Daltimore, IMaryiand 2.1.2.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show			15. Decedent's Edu		Deced	lent's Usual Occupa	ation			16h Ki	nd of Business	White
57 ni 8n" r	ST ST	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most	of working	9	100. KI	ild of Dusiliess	moustry
d with giene.	9	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Clerk	,			C-	rocerv	
Hyg ather	ent,	Ö	17. Father's Name (First, Middle, Last)	110110		OTELK	18. Mother	r's Name	(First, Middle,			
YIANG ould be file Mental Hy arked oth	0	ToB	George Megee				Patr	icia	Leonar	ď		
shound M	mat	-	19a. Informant's Name/Relationship (Ty	pe, Print) 19b	. Mailin	ng Address (Street a					r Town, State,	Zip Code)
Man od 2 sl lith and 27 ls r	rtre		Doris Megee/wife			Champ Ro						
te Hea	othe		20a. Method of Disposition	20b. Place of	Dispos	sition (Name of natory or other place	vau, i	Da	ite		cation - City or	
age ant of	y or		1 ☐ Burial 2 X Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	iemovai mom State				5/9/2	2007		1 1 1	
SAITIMOR Dermit. Pages Department of mportent: If it		4	Signature of Funeral Service/Licens		22	y Cremato  . Name and Addres	ss of Facility	,		Sa.	lisbury	, Maryland
D ed del	once.		mon & Oli	mae 1 M00295	H:	inman Fun	eral	Home	D			ND 01050
			23a. Part1. Enter the disease, or compl	ications that caused the death. Do	not ente	er the mode of dyin	g, such as o	Aveni cardiac or	respiratory arr	nce: rest.	ss Anne	MD 21853 Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause/on each line.								Interval Between Onset and Death
Pnysic /Medi	_	4	resulting in death)	2		ingeal	Concu	2-				241ars.
Exami				Due to (or as a consequence	01):							
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of).							
petr	insit	Examiner	Cause (Disease or injury									
exect	al-tra	Xa	that initiated events resulting in death) Last	Due to (or as a consequence	of):		<del> </del>					
Sicie	puri			4								
BOX 68 / 60, eath certificate be executed attending physicien and	as the	Medical										
ox cent	esn		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy							23d. Date of de	livery
death o	To	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)					Month	Day Year
) å å	ache	Physician	9 Unknown	9□ Unknown								
cords, P.O. BOX w requires that the death cer been signed by the attendin	e det	by P	Part II, Other significant conditions con	ntributing to death but not resulting i	n the ur	nderlying cause give	en in Part I.		23e. Did to	bacco u	ise contribute t	o the cause of death?
w requires to been signe	g pr								1 □ 4	es 2	□No 3□P	robably 4 Unknown
ecol law rec as bee	shor	lete							24a. Was a	an	24b. Were a	utopsy findings available
- 0 C	page 2	Completed							autop: perfor	sy med?	prior to death?	completion of cause of
VICAL P iiclan: Th certificate	or, pa	ပိ	25. Was case referred to medical				00 Pl	-4 D15	1 Yes		1 L Yes	2 □ No
(3)	irect	o Be	avaminar?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	testion	other			(Check only or		6 □Other (Spe	
P F Silling	eral d	$\vdash$	27. Manner of Death		Time of		y at		Bd. Describe h			ecity)
DIVISION  f or Attending after death, Director: Afte	fune	t o	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	njury		k? Yes 2 ⊡ N	No				
Atter dea	y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	eet, factory, office	4-	21				ural Route Number,
after Dire	2	Certification	4 Homicide	building, etc. (Specify)					City or Tow	m, State	)	
spite nours	e lle	alc	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge	e, death	occurred at the tim	ne, date and	d place, a	nd due to the o	cause(s)	and manner a	s stated.
1 24 P	letely	edical	(Check only 2 Medical Exami one)	ner: On the basis of examination an and manner stated.	d/or inv	vestigation, in my or	pinion, deat	th occurre	d at the time, o	date and	place, and due	e to the cause(s)
DIVISION To the Hospitel or Attending within 24 hours after death, To the Funerel Director: After	completely filled in by the	Me	29b. Signature and title of certifier			29c. License	e number		2	29d. Dai	te signed (Mon	th, Day, Year)
			Inta Ivala			005	1359			M	ay 9th	2007
			30. Name and address of person who co	empleted cause of death (Item 23a)	(Type,						1	
5 EL	3		DR-USHA NAT	ESAN . M.D. 14	15	S. DIVISION	I ST,	SAL	ISBURY	, M,	21804	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Acart :						

		For State		ryland / D	I <b>ndelible Inl</b> epartment of Certificate of	Health and N	lental Hy	giene	ble.	16770
Physicia		1. Decedent's Name (First, Middle, Last)  Stephen Michae	el Midway		Jerundate or	Deam	2. Date of De Month	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s		777	4b. City, Town,	or Location of Death	May	2 2( 4c. County	007 of Death	9:20 p. <sup>™</sup>
	illy .	116 Virginia A				ridge			rches	
Funeral		5. Social Security Number 6. Sex	M 2□F	(In yrs. last birth	day) If Under 1 Yea Months Days		8. Date of Bir (Month, Da	ıy, Year)	Cour	* /
Director		216–34–1565 Usual Residence of Decedent		68			Dec. 1	6,1938	Penn	nsylvania
Maryland f show ied at	tor	10a. State 10b. County  MD Dorchest		10c. City, Town		mbridge			10d. Inside City Li 1 <b>X</b> Yes 2 □	
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
th with	al D	116 Virginia Ave	nue		216	513		USA		
ems ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No		e - Americ	can Indian,
ours after ral", or It	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 □ Yes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify		ite
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+		Decedent's Usual Occi Give kind of work don- life. DO NOT use retir	e during most of work ed)	ing	16b. Kind of Bu		dustry
led w lygier her th	Co	12			maintena		(=)	hospi		
be fil	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			e)	
hould d Me mark matic	은	Stephen M. Midway  19a. Informant's Name/Relationship (Type		19h J	Mailing Address (Stree		Mister		State Zir	Codo
nd 2 s Ith an 27 is r trau		Anita Midway	wife		6 Virginia					Code)
s 1 ar f Hea item other	- 1	20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pi	and l	Date	20c. Location -	613 City or To	own, State
Page nent o nt: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	iry Cremato	1	/07	Salisbu	1257	MD
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89 = 89		1 Bikite	>		700 Locus	st St., Car	mbridge	, MD 21	613_	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	neur		crine	The second second second				Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	☐ Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Dat Mor	e of delive	ery Day Year
uires that signed b	d by P	Part II. Other significant conditions con	tributing to death but	not resulting in t	he underlying cause g	iven in Part I.	23e. Did t	/	ribute to th 3□ Prob	he cause of death?
s beer	Completed			-			24a. Was	an 24b. V	Nere auto	ppsy findings available
The la te has age 2	dwo						autor perfo	psy prmed?	orior to cou death?	mpletion of cause of
ian: rtifical tor, p	Be C	25. Was case referred to medical		· · · · · ·		26. Place of Deat	1 Yes		Yes	2 No
nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1   Inpatien	t 2 ER/Outp	atient 3 DOA	No. or or		dence 6 □Othe	er (Specif	·v)
ath. or: After the		27. Manner of Death 1	28a. Date of Injury (Month, Day		ury W			how injury occurr		
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the Hospl in 24 hour the Funer	Medical	one)	ician: To the best of ner: On the basis of and manner stat	examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as s and due to	tated. o the cause(s)
Mith To 1	Σ	29b. Signature and title of certifier	1-		D	\$9887		5/H/C	) 7	Day, Year)
		30. Name and address of person who con David H. Smith, M.			ype, Print) il Dr., Su	ito 5 Eco	ton no	21.01		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		a se	rec o, Eas	COLL PIL	21601		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 7, 2007 **Physician** Virgilio V . Pascual 11:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Marvland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, Funeral Months 1**x**x M 2 □ F 220-53-1627 Philippines Director 63 Aug. 20, 1943 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland 1 4 1 Prince George's Clinton 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9703 Glenview Drive 20735 Philippines death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: Filipino 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Town Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Pascual Juliana Velasco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Modesta J. Pascual / Wife 9703 Glenview Drive Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Clinton, Maryland Resurrection Cemetery May 14, 2007 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA Funeral Service Licensee 21. Signatury 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma orner /Medical Due to (or as a consequence of): Examiner anemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi Examiner death certificate be executed burial-transi whoses and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the. ass IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ſо in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) the 8 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

ANNA IZETTA PARKS

4a. Facility Name (If not institution, give street and number)

FAIRFIELD NURSING HOME CROWNSVILLE ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ■ M 2 □ MF Director 183**-**24-6706 73 PITTSBURG, PA 06/03/33 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Director PRINCE GEORGES MDCLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10219 GOOSE CREEK CT. 20735 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐Yes 2M No FYes, Give 1 ☐ Yes 2 No Specify þ Specify: BLACK 3 Nidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th NURSING\_ASSISTANT MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM D. MINGO 0 IZETTA MEADE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYNN ELLIS/DAUGHTER 10219 GOOSE CREEK CT., CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department o Important: if any injury or once. MARYLAND VETERANS 5/7/07 CHELTENHAM, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 6500 ALLENTOWN RD. Uward CAMP SPRINGS, MD 20748 23a. Part1. En er the dis shock, or he er failu complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 11514 /Medical sequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number of person who completed cause of death (Item 23a) (Type, Print) State 1 6 200 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

Day

30

2007

4c. County of Death

9:30P

2. Date of Death Month

APRIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 12, Leonard John Pirner, Sr. 2007 5:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Southern Maryland Hospital Center Clinton <u>Prince George's</u> If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Months October 1**X**□M 2□F 26,1938 Maryland 68 Director 215-36-5502 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County Charles Maryland 10c. City, Town or Location Waldorf 10d. Inside City Limits ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3035 St. Peter's Church Rd. 20601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \ Yes 2 □ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No "natural", or White Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 198 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Pirner Agnes E. Tippett is marked မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship *(Type. Print)* Ann Pirner/wiie permit. Pages 1 and 2: Department of Health a Important: if Item 27 is any injury or other trauonce. 3035 St. Peter's Church Rd., Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State May 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD 21. Signature of Funeral Service Dicensee 30195 Three Notch Rd., Charlotte Hall; 'мВ·20622 Middles 23a. Part1. Enter the disease, or how cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician olon Counce months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undern in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dusthythmia 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed enaltalure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe )labetes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 TYes 2 TNo 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

0+1

State Registrar

one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Woudorf

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Lillian V Pasquarette May 11:57 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 □ M 2 F 86 219-34-5674 May 22, 1920 Director Maryland | Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 💥 No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12101 Old Annapolis Road 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: white Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own home h and Mental Hygies 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Samuel Tressler Rena Wachter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. 12101 Old Annapolis Road, Frederick, Maryland Michael Pasquarette 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery | 5-10-2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 ☐ Other (specify) P.0. 1 Yes 2 No the 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Completed by 212 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes peen Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy certificate or Vital 26. Place of Death (Check only one) Physician: 25. Was case referred to medical examiner? Be PK No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes ER/Outpatient 3 DOA P 1 Inpatient this funeral 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Year) Division Hospital or Attending 5 ☐ Pending investigation (Month, Day Natural 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fi death. 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

29b. Signature and title of certifie

30. Name and address of

Date filed (Month

MAY 1 0 2007

of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month. Day, Year)

		·	1 - For State Registrar	State of Maryla	•	artment of H		Re	g. No 0 0 7	16784
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las GEORGE	G.	RILEY			2. Date of Death	7 Day Year	3. Time of Death $10:04 \text{ AviM}$
Ž-	Examin Funeral Director		5//-0/-5/25	ENTIST HOSE	PITAL s. last birthday) Yrs.	TAKOMA  If Under 1 Year  Months Days	PARK  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-21-19	4c. County of Death MONTGOME Year) 9 1 0 WAS	RY uplace (State or Foreign
altimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelih and Mental Hygiene. ant: if lem 27 is marked other than "naturel", or items 23a or 28a-f ehow tury or other traumetic event, the Madical Examiner must be notified as	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  DC  10e. Street and Number  4116 - 18TH PL  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0-12)  6TH GRADE  17. Father's Name (First, Middle, Last)  GLENNY RILEY  19a. Informant's Name/Relationship (7)  JEAN R. FREEMAN  20a. Method of Disposition  MyBurial 2 Cremation 3 4	ACE, N. E.  12. Was Decedent Ever in Armed Forces? 1   Yes 20   No If Yes, Give Year or Dates: ucation de completed)  College (1-4or 5+)  Type, Print)  -DAUGHTER  Removal from State	16a. Dece Give life. SUP.	TON  10f. Zip Code 2000  Was Decedent of H If Yes, specify Cuba 1 Yes XXNo  dent's Usual Occup kind of work done of DO NOT use retired  OF PRIN	ispanic Origin? (Sr. n, Mexican, Puerto Specify: ation sturing most of worth NTING 18. Mother's Nam CLAI and Number or Rut RRY ST.	pecify Yes or No- parameters of Rican, etc.)  In the (First, Middle, M RA COLI Tral Route Number, LANHAM Date 2	Og. Citizen of What Cou U. S. A.  14. Race - Amer Black, White Specify: BI  6b. Kind of Business/i	10d. Inside City Limits  1XXes 2 \( \text{No} \)  Intry?  Idea Indian,  ACK  Industry  DEFENSE  Ip Code)  66  Town, State
m	Department Constitution of Con		23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death)	Hinckney	ath. Do not ent	24 - 8T] er the mode of dyin	H ST., 1	N. E. W	SPANGLER ASH., DC st,	Approximate Interval Between Onset and Death
760,	death certificate be executed x x death certificate be attending physicien and m defor use as the burial-transit of	ical Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CARRONY Due to (or as a conse	o PATHY equence of):	C HEART	DISEASE			
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delik Month	very Day Year
	The law requires that the ste hes been signed by th page 2 should be detache	þ	Part II. Other significant conditions of		esulting in the u	nderlying cause give	en in Part I.		acco use contribute to s 2 €No 3 ☐ Pro	the cause of death?
al Reco		Completed	CHRONIL RENAL	INSUPFICIENCY	ĺ			24a. Was an autopsy perform	prior to o death?	opsy findings available ompletion of cause of
Division of Vital Records,	the Hospital or Attanding Physician: Ind A bours deler death.  the Funarel Director: After this certified inpletely filled in by the funeral director, I	on: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpatient 2 [ 28a. Date of fnjury (Month, Day Year)	ZER/Outpatier 28b. Time o Injury		er: 4 🗆 Nursing Ho	th Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spec	rfy)
Divisio	al or Attsndi efter death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)		Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospital of within 24 hours of To the Funarsi D completely filled in	Medicai C	29a. Certifier 1	rsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death nation and/or in	h occurred at the tin vestigation, in my of	ne, date and place, pinion, death occur	and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
ſ	To t To t Com	2	29b. Signature and title of certifier	- MD			25914	29	d. Date signed (Month	, Day, Year)
X	- (N) Sta	te	30. Name and address of person who of ALLEN BRIMMER  31. Date filed (Month, Day, Year)		EAST-	Print) WEST HIGH	WAT, RH	IENDALE, I	40 207	37

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2007 Year **Physician** ROSA Μ. ROMERO MAY 2 7:14 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE MILLENNUM OF FORESTVILLE FORESTVILLE PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🙀 F Yrs. 213-49-8445 94 Director 05-02-1913 PANAMA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD PRINCE GEORGE UPPER MARLBORO Director 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 2134 ROBERT BOWLE DR 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: HISPANIC 9 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER PRIVATE 12th permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, the any Injury or other traumatic event, the staumatic event, the permit is the staumatic event, the staumatic event, the staumatic event, the staumatic event, the staumatic event, the staumatic event, the staumatic event the staumatic event, the staumatic event event event event event event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE HUIE ALBERTA B. BLACK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERTO ROMERO/SON 2134 ROBERT BOWIE DR UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 5-12-2007 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE ALZHEIMER'S DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt be c þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1□ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital To the Funeral 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b, Signature, and title of 29c. License number 29d. Date signed (Month, Day, Year) D51520 MAY 5, 2007 30. Name and address of person who completed cause of death (item 23a) (Type, Print) BAHRAM PISHDAD, MD 1328 SOUTHERN AVE SE #310 WASHINGTON, DC 20032 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Kichardson 2007 Harriss Mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GOLDEN YEARS ASSISTED DAMASCUS MONTGOMERY LIVING If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 T Director 212-32-7103 79 N.C. Apr. 17, 1928 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 77 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, it a Modical Examiner must be notified at Yes 2 No Director MD. MONTGOMERY MT.AIRY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 28928 RIDGE ROAD 21771 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int If item 27 is marked other than "natural", or Ita 1 Yes 27 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4√2 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITALS COLLEGE REGISTERED NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANGUS BLACK CROMERTIE JULIA HARRISS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GALWAY BAY CR. GERMANTOWN, MD. 208 74 JULIA RICE-DAUGHTER 19601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ita any injury or ot once. 1 Aurial 2 Cremation 3 Removal from State ST. PAUL'S CEMETERY 5-17-07 WALDORF, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice MOO 479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MD. 20646

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause breach line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovascellas Thero sclerolic Deleane **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Jeuns Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 No 2 🗆 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 2 ER/Outpatient 3 DQA 5 Pesidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 Tyes 2 No investigation 2 Accident 3 TSuicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 - Homicide 24 hours a 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar 109

201-

32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

161

Saha

Kamesh 31. Date filed (Month, Day, D30641

Back Liver Neck

Road

			State of Maryland / Departm		ental Hyg	iene	1 6 7 0 7
				cate of Death		g. No. 2 U U /	16/8/
	Physici	an	Decedent's Name (First, Middle, Last)  RUTH RAKES		2. Date of Deat Month	Day Year	3. Time of Death
	/Medio			City, Town, or Location of Death	MAY 3	2007 4c. County of Deatl	345 A M
l	LAGIIII	ICI	Shady Grove Adventist Hospital	Rockville		MONTG	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U		8. Date of Birth		nplace (State or Foreign untry)
ŀ	Director		231-24-1044 / 79 Yrs.	Tio Days Flours Will.	8. Date of Birth (Month, Day, Nov. 18	,1927 Vi	rginia
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Many a-f sh fied a	ţoţ	MD Montgomery Gaith	nersburg			1 ⊠Yes 2 □ No
	th the or 28; e noti	Director	10e. Street and Number 10	f. Zip Code	10	Og. Citizen of What Co	untry?
	ath wi	ral	101 Odendhal Road, #502	20877		U.S.A	•
	er de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. If Yes,	ecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5	Irs aft xami	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Ye Year or Dates:	es 21 No Specify:		Specify: Bl	ack
5-003p	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	ted	15. Decedent's Education 16a. Decedent's	Usual Occupation		     16b. Kind of Business	ndustry
Z	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12)   College (1-40r 5+)	of work done during most of working OT use retired)	g		
7	e filed within 7 al Hygiene. I other than "n vent, the Medi	ပိ		Iomemaker		Hom	e
and	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) William Law	18. Mother's Name Eve	(First, Middle, M Lyn Hai	.,	
ar	2 should be n and Mental is marked ( raumatic ev	ř	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Ado	dress (Street and Number or Rural			ip Code) 20877
, Ma	1 and 2 Health a em 27 is			lendhal Rd, #5			
ore	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cernetery, crematory	(Name of Day or other place)	ate 2	20c. Location - City or 1	Town, State
Бащто	trment tant:		4□Donation 5□Other (Specify) / Maryland V			Cheltenha	
a D	permi Depar Impor any Ir			ne and Address of Facility SNC N. Washingtor			
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate
	Physician			- marrow			Interval Between Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	2 11/2/11/04/			weeks
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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ב ב	ath ce	ian/l	23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ Live birth 2 □ Fetal death 3 □ Ectop	pic pregnancy		23d. Date of deli	very Day Year
	the de	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Othe 9 ☐ Unknown	r (specify)		Month	Day real
Ľ	s that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the underlyi	ng cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
COLUS,	equires en sign	ed by			1 □ Ye	s 2 No 3 Pro	bably 4 Unknown
ב ב	law re	Completed			24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	ding Physician: The In. After this certificate hat funeral director, page	E O		· · · · · · · · · · · · · · · · · · ·	autopsy perform	prior to condeath?  ☐ No 1 ☐ Yes	
ומ	cian: sertific setor,	Be (	25. Was case referred to medical examiner?	26. Place of Death			
5	Physical this call dire	P	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Magner of Death 28a. Date of Injury 28b. Time of			nce 6 Other (Spec	ify)
5	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	8d. Describe ho	w injury occurred	
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5	tal or s after al Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town	State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occu 2 ☐ Medical Examiner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place, ar ation, in my opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	, Day, Year)
			> Nohm	0.20198	,	3 M24	2007
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Il Ave Ga	theobu	ce My	
	Sta		31. Date filed (Month, Day, Year) 9 2007 32. Rightstrar's Signature	AF 0	-,4000	3	
	Registra	ar	mini o a con produce to began				

07-03490

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Patricia	Marion	Reynolds	

	- F	1- For State Registrar			ficate of Dea		tai i iygierie	Reg. I	No. 200	7 1678
Physician Medical Examina		1. Decedent's Name (First, Middle,La Patricia		yno1	da		2. Date of Month	n Da	ay Year	3. Time of Death 0330 hrs
		4a. Facility Name (if not institution, g		ymore		, Town, or Location		7, 2007	4c. County of Death	
		3914 Baltimore Street  5. Social Security Number 6. 9	Sex 7. Age (In	.um last		sington	2411= 10 Date	of Dieb (	Montgomery  MM/DD/YYYY) 9. Bird	h-1(6)
Funeral Director		2// 1/ 0270	M 2 XF 8	•	Yrs.		Min	,	Foreig	
any	f	10a. State 10b. County	10c	. City, To	wn or Location					10d. Inside City Limits
Maryfand 28a-f show d at once.	힏	Maryland Montgor	nery	I	Kensingto					1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	E	10e. Street and Number 3914 Baltimore			10f. Zip Code 20895				Citizen of What Cour	
er death wi	by Funeral		1 Yes 2 A	No	If Yes, spe	dent of Hispanic Orig cify Cuban, Mexican 2 X No specify:	, Puerto Rican, et		14. Race - Ameri White, etc. White Specify:	can Indian, Black,
hours natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	conly highest grade complet	ed) 16		al Occupation (Give orking life, DO NOT		16	b. Kind of Business/I	ndustry
nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene. It: If item 27 is marked other than 19 other traumatte event, the Medical	Completed		5+		Teac				School	
215-( be filed be filed by the	မ်ိဳ	17. Father's Name (First, Middle, Las Fred Willia	,				's Name (First, Mi 11a Ne1		ten Surname) illiams	
ore, MD 2121; s. I and 2 should be fil s. Health and Mental. If item 27 is marked ler traumatic event,		19a. Informant's Name/Relationship							r, City or Town, State	. ,
e, MD and 2 sho fealth and item 27 is traumat	-	David P. Reynol  20a. Method of Disposition			ce of Disposition (N		, Monro		Maryland Oc. Location - City or	Z1770 Town, State
Pages 1 ment of 1 lant: 1f	١	1 X Burial 2 Cremation 3 4 Donstion 5 Other Specif			matory or other places	1 Cemeter	y 5/12/	07 1	Monrovia,	Marvland
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	Ī	21. Signature of Funeral Service Lice		21 2	22. Name ar Moles 26401	nd Address of Facility Worth-Wil Ridge Ro	liams P.	A., I	Funeral Hos, Marylan	ome dd 20872
Physician	1	23a. Part I. Enter the disease, or comfailure. List only one cause on	aplications that caused the each line.	death. Do	o not enter the mod	e of dying, such as c	ardiac or respirato	ory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Smoke Inhalation A		ermal Injuries					Death
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):						
	[]	cause. Enter Underlying Cause (Disease or injury that initiated								
cuted nd transit	•	events resulting in death) Last	Due to (or as a conseque	nce or):						
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Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknow	Pregnant at time Unknown	of death	5 Other (Sp	pecify)		_		
ires that the disagrant to be detached	by Ph	Part II. Other significant conditions	contributing to death but	not resul	Iting in the underlyi	ng cause given in Pa	rt I. 23e.		cco use contribute to	the cause of death?
v requires							24a.	Was an	24b. Were au	topsy findings available
of Vital Records,  ng Physician: The law require wher this certificate has been si meral director, page 2 should b	Completed						—	autopsy performe Yes 2	d? death?	ompletion of cause of
tal Rection: The certificate ector, page	ည် - ရှိ	25. Was case referred to medical examiner?				26.Place of Death		100 2		3 2 10
f Vid	의	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		R/Outpatient 3	DOA Other	Nursing Home		sidence 6 V Other	: Scene
ion of tending Planth ort After the funera	tion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) May 7, 2007	- 1	220 hrs	28c. Injury at Work 1 Yes 2 ✓	Subject		injury occurred dental house fire	е
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed then safter death.  Hours after death.  Financial Direct After this certificate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the burial - transity Certification: TO Be Computed.	Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury			ry, office building, et	or To	own, State		ral Route Number, City
Division  Division  To the Hospital or Attend within 24 bours after death To the Fineral Director: completely filled in by the	<u> </u>	29a. Certifier 1 Certifying Physic	cian: To the best of my known: On the basis of examinar	wledge,	death occurred at t		ce, and due to the	e cause(s)	and manner as state	ed.
To the within To the complete	<u> </u>	29b. Signature and title of certifier	and manner stated.			9c. License number			d. Date signed (Mor	
	- 1									
		Panet Fouther	(,011)		-	O.C.M.E.		∿	1ay 8, 2007	
0		30. Nam and the sof person who Pamela E. Southall, MD	completed cause of death Assistant Medical	Evami	nor 111 Don	O.C.M.E.	ore, MD 2120		lay 8, 2007	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryland / Dep	artment of Health and Nertificate of Death		ene 2007 16789
Phys	ician dical	1. Decedent's Name (First, Middle, Last) Gliceria Sovero		2. Date of Death Month May	Day Year 7:54 p M
Exan		4a. Facility Name (If not institution, give street and number) 2003 Charleston Place	4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince George's
Funer: Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 19–45–5117 7. Security Number 7. Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y 2/15/193	9. Birthplace (State or Foreign Country) Peru
parifficier, Wal ylaffic ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fleen Z1 is marked other than "natural" or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	10a. State   10b. County   10c. City, Town or Let	1e  20783  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto I ☑ Yes 2□ No Specify: Perecedent's Usual Occupation exim of work done during most of work DO NOT use retired)  18. Mother's Nam Unkn ing Address (Street and Number or Run osition (Name of ematory or other place)	e (First, Middle, Ma  OWN  ral Route Number, C  yattsvill  Date 20	e, MD 20783 c. Location - City or Town, State
Physicia /Medica Examine	n al	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, searing to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		t Lincoln d., Brent or respiratory arrest	Funeral Home wood, MD 20722
s, F.O. DOX, est that the death certification by the attending be detached for use as	by Physician/Me		□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.		23d. Date of delivery Month Day Year co use contribute to the cause of death?
ificate has been sion, page 2 should b	e Completed	25. Was case referred to medical	00.00		24b. Were autopsy findings available prior to completion of cause of
or Attending Physician: The after death.  Director: After this certificate he in by the funeral director, page	Certification: To Be	examiner?  1   Yes   2   No	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	et and Number or Rural Route Number,
To the Hospital or Attend within 24 hours after death.  To the Funeral Director: /	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caus	se(s) and manner as stated. e and place, and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier  Mathematical States of the Control of the	29c. License number  0 - 2 33 0 8		Date signed (Month, Day, Year)  MAY 8, 2007
R (2)	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e Drive, Bethesda,	MD 2081	7
Regis	strar	MAY 0 8 2001 Face D. Special			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day ROBERT CHARLES 29, STIDHAM APRIL 2007 8:25 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 10, 1959 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 **X**M 2 □ F ountry) Illinois 47 578-86-9901 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f shove the Medical Examiner must be notified at Director MDMontgomery 1 Yes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 432 Gaither Street 20877 U.S.A. Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) yrs Merchandiser Best Buy traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Stidham Helen Ann Williams ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Helen A. Stidham (Mother) 432 Gaither St, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐Removal from State Gate of Heaven Cem 5/8/07 4 Domation 5 ☐ Other (Specify) Silver Spring,MD e of Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 de disease, or domplications that caused the death. It not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic Shock disease or condition resulting in death) Hours /Medical Due to (or as a consequence of) **Examiner** Cellulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Days Due to (or as a consequence of): Examine the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 cate has been signated bage 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforn certificate 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes № No 2 ER/Outpatient 3 DOA P 1X Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 30th, 2007 MD 110064560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockville, MD SINGH NIKHANS NIOHI 9901 Year) strar's Signature State 2007 09 Registrar

			For State	State of N	Marylan		artment of I			ental Hy	giene	000=	
			Registrar  1. Decedent's Name (First, Middle, Las	st)		Cel	rtificate of	Death		2. Date of Dea	Reg. No.	2007	3. Time of Death
	Physici		Rita Agnes	•	Stanb	rough				Month ay 5,	Day	7 Year	8:25 A <sup>M</sup>
	/Medio Examir		4a. Facility Name (If not institution, give	e street and numbe	er)		4b. City, Town,	or Location of				ounty of Death	0,23 11
			Frederick Memori				Frede		Od Han La			ederick	
	Funeral Director		5. Social Security Number 6. S 579–22–0809		Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days		Min.	B. Date of Birt (Month, Day an 25,	h v, Year) 1922	Cou	place (State or Foreign htry) Lngton DC
Н	D		Usual Residence of Decedent							un 25,			
	show	2	10a. State 10b. County	1		ty, Town or Lo							10d. Inside City Limits 11 Yes 2 No
	the N 28a-f	Director	Maryland Frederi  10e. Street and Number	.ck	11	rederio	10f. Zip Code				10a. Citize	en of What Cou	
	th with 23a or ist be	a Di	311 East 9th Stre	et			217	01			US		,
စ္	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 23a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Deceder Armed Force 1 ☐ Yes 2 If Yes, Give	s? XINo		Was Decedent of lif Yes, specify Cub			fy Yes or No- can, etc.)		4. Race - Americ Black, White, Specify: Wh	
2-0036	tural'		3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates	s:	16a. Dece	dent's Usual Occu	pation				d of Business/In	dustry
<u>V</u>	within 72 iene. than "ns the Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4c	or 5+)	(Give	kind of work done DO NOT use retire	during mos	it of working	,		3 3 3 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	duotiy
V	al Hygien I other than		12			Bus I	river	T				Public	School School
and	d be fil ental H ed oth	Be	17. Father's Name ( <i>First, Middle, Last)</i> Lewis		Wes	st		18. Mothe		First, Middle, Agn		<sub>urname)</sub> Sartair	1
5	2 should be f and Mental F Is marked of raumatic ever	ဥ	19a. Informant's Name/Relationship (	Type. Print)			ng Address (Stree						
Ma.	and 2 lealth a m 27 is		Lois Clow/Daughte	r		311 E	ast 9th	Stree	t, Fr	ederic	k,MD	21701	
•	ges 1 If iter or oth		20a. Method of Disposition  1 △ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	te C	cemetery, crei	sition (Name of matory or other pla		Dat			ation - City or To	
Saltimor	permit. Pages ' Department of H Important: If Ite any Injury or ot		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Gat		Leaven Ce		/10/20	2.4		er Spri	
מ	Depart Impo		How				21 Oposs						
ı			23a. Part1. Enter the disease, or com thock, or heart failure. List only	plications that caus pne cause on each	sed the deat	h. Do not ent	er the mode of dy	ing, such as	cardiac or i	respiratory ar	rest,		Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition resulting in death)	α.	zure								Onset and Death
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	n *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	as a conseq	uence of);	tension eart f	-					
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Ŏ	tificate ig phys as the	ledic		- d					187				
Š	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth			Ectopic pregnanc	у			23	3d. Date of delive	ery Day Year
- -	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		leath 5	Other (specify) _					WICHTI	Day Teal
ν. Γ	requires that the een signed by the rould be detache	by Ph	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the ur	nderlying cause gi	ven in Part I.		23e. Did to	bacco use	e contribute to the	ne cause of death?
ecords,	equire en sig ould b									1 🗆 Y	'es 2□	No 3 ☐ Prob	pably 4 nknown
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VII	n: Th ficate or, pag		25. Was case referred to medical							perfor 1□ Yes	2 No	death? 1 ☐ Yes	2 No
	ysicia is certi directo	To Be	examiner?	Hospital: 1 Inpa	atient 2 🗆	ER/Outpatien	t 3 DOA Ott	DOF:		Check only o		□Other (Specif	i/
5	Attending Physician: It death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Ir		28b. Time of				d. Describe h			y)
2	ttendl death. stor: A	icatio	2 Accident investigation 3 Suicide 6 Could not be		inium. At he	amo form etc		Yes 2 1		£ 1 1 /6			
<u> </u>	after after of in Direct din by	Certification:	4 ☐ Homicide determined		etc. (Specif		eet, factory, office		281	City or Tow	n, State)	Number or Hura	Il Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: Ther this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be- niner: On the basis and manner	of examina	owledge, death	n occurred at the t vestigation, in my	ime, date an opinion, dea	nd place, an ath occurred	d due to the d	cause(s) a	and manner as solace, and due to	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	- 1			29c. Licens					signed (Month,	
			1 And y	Ny	M9		Do	0550	61	/	May	9, 2	207
1			30. Name and address of person who Dr. Aubrie Nagy	300 W N	inth S	Street	Frederi	.ck, M	D 217	01			
4	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. 501	strar's Signa	ture A	berte						

DHMH 17 Rev 1/2001

			Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year 3. Time of Death			
	Physici /Medic		Lauretha	TALLEY						30	a co 7	12:37PM
No.	Examir		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, o	r Location	of Death		4c.	County of Death	
į.			MONTGOMERY GENERAL HOSPITAL		Olne	<u> </u>					Montgom	ery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birth	day) If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. 8	B. Date of Birt (Month, Day	h	9. Birth	pplace (State or Foreign intry)
	Director		579-22-8455 1□ M 2 TF 91	Υ	rs.	Days	Hours		ec. 4,			muy)
	pu ,		Usual Residence of Decedent	c. City, Town or Location								
	anylan show d at	_	10a. State 10b. County 10c. City	y, Iown	or Location							10d. Inside City Limits
	Ba-f	cto	MD Montgomery	Sil	er Spri	ing						1 ☐ Yes 2X No
	or 20	Director	10e. Street and Number		10f. Zip	Code				10g. Citi	zen of What Cou	intry?
	ath w 23a ust t	<u>ra</u>	15007 Haselmere Ct.			209	06				USA	
	r deg	Funeral	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?	S.	13. Was Deced	dent of H	lispanic O an, Mexica	rigin? (Spec an, Puerto R	ify Yes or No-		<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No If Yes, Give		1 ☐ Yes		Specify		,		Specify:	,
5-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	g p	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	40.5							. В	lack
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2121	withii ene. than	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+) 8th			se remed	<i>1)</i>			D	T	
	filed Hygi ther	ပ္	17. Father's Name (First, Middle, Last)	<u> </u>	tering		18. Moth	er's Name /	First, Middle,		ivate F	amilies
au	be do	Be	George Campbell							maiden	ourname	
Maryland	should be filed vand Mental Hygies marked other tumatic event, th	은	19a. Informant's Name/Relationship (Type. Print)	10h I	Mailing Address	(Stroot		a Cam	<u> </u>	Cit	r Town, State, Zi	
<u>B</u>	d 2 sho th and 7 is ma traum			1								
ė,	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Helen Talley/Sister-in-law  20a. Method of Disposition 20b. P		Critte Disposition (Nan		n St.	NE Da			DC 20 cation - City or T	
ğ	00 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery	crematory or o	ther plac	ce)			200. 20	. Oily of 1	own, state
altimore,	it. Purtue		4 □ Donation 5 □ Other (Specify) Mar  21. Signature of Funeral Service Licensee	ylar	nd Natio			5-7-2			rel, MD	•
Ba	permit. Pag Department Important: ii any injury o		21. Signature of Purietal Service Licensee	)					Home, I			
-			230 Per Enter the disease or complications that accord the depth	Do 20	4217 9						,DC 200	
			23a. P.M. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do no	t enter the mod	e ot ayır	ig, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
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	ted	Examiner	Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	OSCLEROTIC COROWAR, quence of): PDIAL IN FARCTION								
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9	be e										Ì	
Box 68760,	ficate phys	an/Medical	a		-			_			-	
X	certi nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregna	incy							3d. Date of deliv	(OD)
ŭ	atte atte		in the past 12 months?		3 ☐ Ectopic pr 5 ☐ Other (sp		/				Month	Day Year
o	the c y the iched	Physic	1 ☐ Yes 2 🔀 No 4 ☐ Pregnant at time of do 9 ☐ Unknown 9 ☐ Unknown		- D (op							
Vital Records, P.O	that ned b	V Pt	Part II. Other significant conditions contributing to death but not resu	ulting in t	he underlying ca	ause giv	en in Part	I.	23e. Did to	bacco u	se contribute to	the cause of death?
g	uires n sign ld be	d by	- HYPERTENSION						101	/es 2[	]No 3 ☐ Pro	bably 4 Onknown
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<u>&gt;</u>	or A after Direction by	ertification:	4 Homicide determined building, etc. (Specify	y)	i, sireei, iaciory	, once		28	City or Tou	n, State,	Number or Hui	ral Route Number,
	poitai ours erai filled	O	29a. Certifier 1 Certifying Physician: To the best of my kno	wledge	death occurred	at the tir	no data a	and place or	ad due to the			-4-4-d
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)  2 Medical Examiner: On the basis of examina and manner stated.	tion and	or investigation,	, in my o	pinion, de	ath occurre	d at the time,	date and	place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier		290	: Licens	e number			29d, Date	e signed (Month	Dav. Year)
	⊢≯Fŏ		Robert f. Larden M	non		D		001				,
^				111			/	18/3		09	-30	-2007
14	- (6)		30. Name and address of person who completed cause of death (Item Robert F. Larkin, MD 18101 Pri			o Dr	. 0	lnev.	MD. 20	832		
	Sta	te						, ,				
	Registr		31. Date filed (Month, Day, Year)  NAY 0 8 2007	Joen	a)							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dorothy Elizabeth Thomas 11:40 P M 2007 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayside Care Center St. Mary's Lexington Park 8. Date of Birth (Month, Day, Year) January 15,1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Davs Hours 1 □ M 2 🙀 F 531-14-4320 92 Washington Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at 28a-f show 1 ☐ Yes 2 X No Director Mechanics ville Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ltems 23a c 20659 USA 35605 Aviation Yacht Club Road by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 🌠 No If Yes. Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ♥ Widowed 4 Divorced White "natural", ear or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be If item 27 is marked or other traumatic ev Steven Clement Marvin Maria Carolina Parvianen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 35605 Aviation Yacht Club Road, Mechanicsville, Maryland 20659 John Edward Thomas / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Episcopal
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 19, 2007 Chaptico, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the diseas i, or complete in sthat caused the dath, shock, or heart failure. List only one cause on e in line. -P.O. Box 270, Leonardtown, Maryland 20650 Approximate Interval Between Onget and Death Do not enter the mode of dying, such a cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (o Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 te ha performed? 2 No certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1. Natural 1 Yes 2 No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and tite of certifier cause of death (Item 23a) (Type, Print) of person who com James P 4035 Three Notch Road, Hollywood, Maryland 20636 Jarboe, M.D. Day, Year) 32. Registrar's Signature State 8 2007 Registrar

			For Stete Registrar	State	of Maryla		artment of Fertificate of			lental H	giene	007	1 16791
	Physic	ian	1. Decedent's Name (First, Midd.	le, Last)						2. Date of D	eath	001	3. Time of Death
	/Med			RTHORNE	TAYLOR					Month May	8 20	Year	10:45 PM
	Exami	ner	4a. Facility Name (If not institutio				4b. City, Town, o	r Location	of Death			unty of Deat	th
-	Funcual		Berlin Nursing 5. Social Security Number	& Rehabi.		n Ctr.	Berlin  If Under 1 Year	T (t)	0411			ceste	
And a	Funeral Director		219–07–8736 Usual Residence of Decedent	1 M 2 F	7. Age (III yi	90 Yrs.	Months Days	If Under Hours	Min	8. Date of Bi (Month, D Jan. 3	av Vaarl		hplace (State or Foreign untry) rginia
	yland how		10a. State 10b. County		10c. (	City, Town or L	ocation						10d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Co	untry?
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	ier de Items	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori	gin? (Spe	cify Yes or Ne	0- 14.	Race - Amer Black, White	
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215-0036	2 hou		15. Deceden	t's Education		16a, Dece	dent's Usual Occupa	ation	_			, WI	nite
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rei	hould be d Mental narked o natic eve	10	Benjamin Russe		rthorne					Dishar			
Ma	d 2 sho th and t7 is m traum		19a. Informant's Name/Relations				ng Address (Street a						
or or	Health tem 27 other tr		William C. Taylo  20a. Method of Disposition	or (son)	[20b.	Place of Dieno	Silvertho			New Ch			
yl(	Pages nent of I		1⊠ Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐Removal from	State	cemetery, crei	matory or other place	1			20c. Locatio		
Taylor Baltimore,	- 4 4 -		21. Signature of Funer Service		POR	tersvill	e Cerretery	s of Facility	5/12/	2007	Stockt	on, Ma	aryland
	permi Depar Impor any Ir		Michael 1	Dem	7	He Pe	Name and Address Colloway Focomoke C	unera ity,	1 Hor MD 2	ne, Pro 1851	ofession	al Asso	ciation
	Physician and /Medical Examiner sthe private in the	dical Examiner	23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to c.	(or as a consection as a conse	quence of):	Cardiou						Approximate Interval Between Onset and Death
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0	ding Pnysician:  After this certific funeral director,	2	1 Yes 2 No			ER/Outpatient		4 La Nurs	sing Home	5 ☐ Resid	ence 6 □O	ther (Specif	iy)
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			For State Registrar	State of IVIa	aryiand / L	Certificate of		- '	giene Reg. No. 🔈 🧻 !	07 1	6795
16.	Physicia	an	1. Decedent's Name (First, Middle, La	st)				Date of Dea     Month	Day	Year	Time of Death
	/Medic		John C. White					May 3			:18 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, given	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, c	or Location of Dea	th	4c. County o	of Death e Georg	
	The state of the s		Laurel Regiona  5. Social Security Number 6. S		e (In yrs. last bir			8. Date of Birt			(State or Foreign
Se 2	Funeral Director			1 <b>X</b> M 2□ F		Yrs. Months Days	Hours Min	8. Date of Birth (Month, Day 1/11/19	16 V	Country) Vashing	
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	Mary I-f sh	tor	FL Simino	Le	Winter	Springs				1	X Yes 2 □ No
	n the	irec	10e. Street and Number		L	10f. Zip Code			10g. Citizen of W	hat Country?	
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10	d within 72 hours after death with the Maryland giene. rr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent! Armed Forces? 1 X Yes 2 1		13. Was Decedent of I		Specify Yes or No- rto Rican, etc.)	Black	- American Inc. , White, etc.	· ·
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121	within ene	шb	Elementary/Secondary (0-12)	College (1-4or 5		`life. DO NOT use retire	ed)		C		
22	filed w Hygie Ither t		17. Father's Name (First, Middle, Las	*)	50	pervisor	18. Mother's Na	ıme (First, Middle,	Govern  Maiden Surname		
and	be d d	Be c	Leonard August	•				la Harvey		-,	
Ž	s 1 and 2 should by Health and Mente tem 27 Is marked other traumatic e	2	19a. Informant's Name/Relationship		19b	. Mailing Address (Street				State, Zip Cod	/e)
Ma	and 2 sealth ar n 27 Is		Dorothy L. Reddi		r 11	675 Foxspur	· Ct F11	icott Ci	ty MD 21	042	
re,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition			Disposition (Name of ry, crematory or other pla	uce)	Date	20c. Location -		State
m 0			1X Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci			ncoln Cem.		5/07	Brentwoo	od,Mary	land
Baltimore,	permit. Page Department Important: II any injury or		21. Signature of Funeral Service Lice	nsee	ン	22. Name and Addre	ess of Facility <b>Ft</b>	. Lincol	n Funera	ı1 Home	
190		_	23a Part1, Enter the disease, arcon	mileations that caused	the death. Do	3401 Blade	nsburg R	Rd. Brent	wood, Md	App	proximate
16			shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	,	3,	, , , , , , , , , , , , , , , , , , , ,	,	Inte	erval Between set and Death
	Physician /Medical		disease or condition resulting in death)		estive a consequence	Heart Failu	re			1	week
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or Vital Records,	The law requires that the death cer tte has been signed by the attendin bage 2 should be detached for use	d by	Cardiomyopothy	7				10	Yes 2□ No	3 ☐ Probably	4 <b>X</b> ]Unknown
CO	aw require s been si should b	Completed	Chronic Arter	ial Fibril	lation			24a. Was		Vere autopsy f	findings available
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ta		Be C	25. Was case referred to medical				26. Place of De	eath (Check only o			140
>	Physician: r this certific ral director,	To B	examiner? 1 □ Yes 2 <b>X</b> No	Hospital: Inpatie	ent 2 ER/Ou	ıtpatient 3 DOA Ot	her: 4 \( \text{Nursing}	Home 5 ☐ Resid	dence 6 □Othe	er (Specify)	
0	ding Pt n. After th funeral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inju (Month, Da		Time of 28c. Injury	iry at ork?	28d. Describe	now injury occurre	ed	
Sio	Attending r death. ector: After by the funer	atic	2 ☐ Accident investigation				]Yes 2 □No				
Division	l or Att after de Direct I in by t	Certification:	3 Suicide 6 Could not to determined	20e. Place of in	ury - At home, fa c. <i>(Specify)</i>	ırm, street, factory, office		28f. Location (5 City or Tox	Street and Numbe vn, State)	er or Rural Ros	ute Number,
Ω	ospital or Attend hours after death uneral Director:		COn Contition 1 To Continuing P	hypinian To the heet	of my knowledge	a death accurred at the t	ima data and ala	on and due to the	souse/s) and mo	anner an etated	
	I 4 II 5	edical			f examination ar	e, death occurred at the t nd/or investigation, in my					
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	0		29c. Licen	se number		29d. Date signed	i (Month, Day,	Year)
	7		1	HO-E	~ VI	D002	4721		May 3,	2007	
( )	2(14)		30. Name and address of person who Syed Sadiq 14333	completed cause of d	leath (Item 23a)	(Type, Print) d, Laurel M	D 20708				
	Sta		31. Date filed (Month, Day, Year) MAY 0 8 2007	32. Registr							
	Registi	ar	11/1 0 /2 2001	March 1	-						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 Charles Weaver 7:45p May Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Crofton Convalencent Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 XM 2 □ F Hours Director 302-07-0571 89 11/29/1917 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Items 23a or 28a-f show Iner must be notified at Director MD Prince Georges Bowie 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12607 Killian Lane 20715 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specifi White þ 3 Widowed 4 □ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within all Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Property Manager Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental F ' is marked ot Robert Allen un-avail. Laura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Weaver/Son Health tem 27 i 12607 Killian Lane, Bowie Maryland 20715 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem. 4 Donation 5 Dother (Specify) 5/7/2007 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladenburg Rd., Brentwood, MD 20722 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alz **Physician** disease or condition resulting in death) /Medical Due to mas a consequence of) phalopathy Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit certificate be executed Hyperterm VC Duato (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ed by the a Records, P.O. 9☐ Unknown 9 Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 1□ Yes 1 ☐ Yes 2 No Division or Vital 2:X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Medical Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled the Hospital 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

10

State Registrar

Rakesh Arora, M.D. 31. Date filed (Month, Day, Year,

MAY 0 8 2007

29b. Signature and title of certifier

14300 Gallant Fox Lane, Suite 222, Bowie, MD 32. Registrar's Signatu

on anona

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Muriel O. Whelan April 28. /Medical 7:35 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 □ Hours Director 026-12-5223 Oct 7, 1920 Massachusettes Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2☐No Examiner must be notifled Virginia Fairfax Director Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ŏ 23a 6216 Sonepath Cir. Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Nidowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once. George Fafard ဥ Jayne Ann Coburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Ralph - Daughter 6216 Stonepath Cir. Centreville, VA 20120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. May 23, 2007 Arlington, VA 22. Name and Address of Facility Everly Funeral Home 21. Signature of Funeral Service Licensee 10565 Main St. Fairfax, VA 22030 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as only one cause on each line. 23a. Part1. Entry the disease shock, or part failure. Approximate Interval Between Onset and Death Immediate Courtion (Final disease or condition resulting in death) Physician SEPSI /Medical Due to (or as a consequence of): Examiner URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Year Dav 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No

The law requires that the death certificate be executed 735AL 68760. 0 Box Ś 2 O 0 Division or Vital Records, Mure 1) he Lan After

Baltimore, Maryland 21215-0036

I Director: A

e Hospital or Attending Physician: 24 hours after death. n 24 hours af he Funeral D oletely filled in

To th	withir	To th	comp
5	2	)	
1			

Medical

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier

0 9 2007

6 ☐ Could not be

determined

29c. License number 0005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ruong 31. Date filed (Menth, Day, Year)

2 Accident

3 ☐ Suicide

4 ☐ Homicide

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Olga Eval Milkerson  Many 1, 2007  1	
Olga Eval Wilkerson  May 1, 2007  Examinor  A. Facility Name of Treatments of Treatmen	7 10700
Security Comments   Security Number   Security	3. Time of Death- 12:44 P M
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Physician // Medical Examiner  Physician // Medical Examiner //	W YOTK  10d. Inside City Limits  1X□ Yes 2□ No
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Physician / Medical Examiner   Medical Examiner   Part   Pa	
Due to (or as a consequence of):    Chronic Obstructive Pulmonary Disease   Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Due to (or as a consequence of):    Due to (or as a consequence of):	
D30132 Date signed (Month, Day, May 7, 2007	
D30132 Date signed (Month, Day, May 7, 2007	delivery Day Year
D30132 Date signed (Month, Day, May 7, 2007	
D30132 Date signed (Month, Day, May 7, 2007	
D30132 Date signed (Month, Day, May 7, 2007	Assisted
D30132 Date signed (Month, Day, May 7, 2007	pecify) Living
D30132 Date signed (Month, Day, May 7, 2007	Rural Route Number,
D30132 Date signed (Month, Day, May 7, 2007	as stated. fue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mahashweta Rita Ghosh MD 14812 Physicians Lane Rockville, MD 20850	
State Registrar  31. Date filed (Month, Day, Year)  MAY 0 9 2007  32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician IRENE P. WALES MAY 2007 11:00AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CAROLINE CAROLINE NURSING & REHAB DENTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 M 2 F Months UNITED KINGDOM OCT 30, 1921 85 Director 217-44-2144 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ma 23a or 28a-f ahow 1 √2 Yes 2 □ No Director EASTON TALBOT 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 21601 USA 106 W. EARLE AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Examiner Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 21215-0036 9 1 Tes 2 No If Yes, Give Year or Dates: Specify: WHITE þ 3 N Widowed 4 Divorced "natural" or than "natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING SEAMSTRESS 8 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be and Mental FLORENCE JUPP ARTHUR BAULEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 Is any injury or other trac 111 PROSPECT AVE., EASTON, MARYLAND 21601 PAMELA J. NEWELL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/5/2007 ST. MICHAELS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) OLIVET CEMETERY 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Josephi W. Ostroush C.F. S.P. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) weete **Physician** erepra /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attanding Physicien: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 5 Other (specify) o the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ briknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe rmed? 2 12 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4 Unursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) legistrar's Signature 31. Date filed (Month, Day State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 9Day 200<sup>7</sup>7<sup>ar</sup> 1:45 A M Wenk Ruth **Physician** Janet /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg 124 Tulip Drive If Under 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days Hours **Funeral** 1 □ M 2 F 12, 1947 Maryland 59 Oct. 161-40-9685 Director Usuat Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after deeth with the Maryland 10b. County 10a. State 27 is marked other than "natural", or iteme 23s or 28a-f ehow traumatic event, the Musical Examinat must be notified at 1 XYes 2 No Director Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20877 U.S.A. 124 Tulip Drive Be Completed by Funeral 14. Race · American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes. Give 11. Maritat Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 XNo Specify. Baltimore, Maryland 21215-0036 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Office of Consumer al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Protection, Montg. Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental George R. Hartz Elizabeth Muir P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17967 Amy Lynn Breese - Daughter 80 Breisch Road, Ringtown, Pennsylvania Health Item 27 other 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nant of t 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: if any injury or once. Montgomery Meth. Cemetery 5/11/07 Damascus, Maryland 5 Other (Specify) 4 Donation Nume and Address of Eachity Address of Eachity P.A., Funeral Home 26401 Ridge Koad, Damascus, Maryland 21. Signature of Funeral Service Licensee Funeral Home 20872 Frest 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) eloma Ole Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the deeth certificate be executed signed by the attending physicien and d be detached for use as tha burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23d. Date of detivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 X No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို this 28d. Describe how injury occurred 28c. tnjury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death Certification: After 1 XNatural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: / 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge death accurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064615 May 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DICCORD Dr. Rockville MD 20852 Wroblewski MD. 1355 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DONALD GRAHAM WALL 3:10P M MAY 14,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7425 ROBIN ROAD LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 237-48-74451 DM 20F Director 73 FEb.5,1934 N.C. Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director CHARLES MD. LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 7425 ROBIN ROAD 20646 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Acs, Give ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married MARINI ARMI Year or Dates: 1954-56 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANICAL ENGINEER U.S.GOVT. 4YRS.COLLEGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES V. WALL ဥ THELMA BAKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTELLE WALL-SPOUSE 7425 ROBIN RD. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Neurial 2 Cremation 3 Removal from State TRINITY MEM. GARDENS 5-22-07 WALDORF, MD. RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 MO0479 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung **Physician** Lan cer /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Examiner Box 687605 or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death Check only one examiner? No No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 일 Other: 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Yes 2 No Il Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 33426

State

Registrar
DHMH 17 Rev 1/2001

JENKINS, M.D. LaGRANCE AVE. LA PLATA, MD. 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LARRY

			For State Registrar	State of Ma	aryiand		ariment of F rtificate of		мептат ну	giene Reg. No.	2007	16803
14	Physici	an	1. Decedent's Name (First, Middle, Las	)					2. Date of De	eath Day	y Year	3. Time of Death
	/Medic			tton	York				May 7	,200	07	8:49a <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give	,				r Location of Dea	ıth		County of Death	
- 3-1	Funeral		Shady Grove Ac 5. Social Security Number 6. Se		e (In yrs. las	st birthday)	Rockv If Under 1 Year	IIIE		rth	Iontgom	
b	Director		331-20-2004	M 2□F	72	Yrs.	Months Days	Hours Mir	1. (Month, Da 3/08)	193 <b>1</b>		place (State or Foreign ntry) eenup, IL.
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	Maryl a-f sho fied a	tor	MD Montgom	ery	Mo	ntgo	mery Vi	llage				1X Yes 2 □ No
	th the or 28¢ e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?
	ath wi	ral	19251 Dunbridg		_		2088				USA	
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matce event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	105	J =	Was Decedent of H f Yes, specify Cub l □ Yes 2⊠ No		Specify Yes or No rto Rican, etc.)	0-	14. Race - Ameri Black, White Specify: W	
2	72 hornatur	eted	15. Decedent's Edi	ucation de completed)		(Give	dent's Usual Occup	during most of wi	orkina	16b. Ki	ind of Business/Ir	ndustry
21215-0036	filed within 72 Hygiene. other than "nai set, the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	oo NOT use retire artment	d)	-	Fed	deral G	overnment
Q 2	filed Hygie	ပို	17. Father's Name (First, Middle, Last)	- 1				18. Mother's Na	me (First, Middle	, Maiden	Surname)	
Maryland	12 should be f h and Mental I r Is marked of raumatic eve	To Be	Troyt B.York					Louise	Butto	n		
ary	2 shot and N Is mai		19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	g Address (Street	and Number or F	Rural Route Numb	per, City o	or Town, State, 2	0866
	es 1 and 2 should to the literal and Mento of Health and Mento the literal and the rother traumatice		Virginia York/	Wife	1							llage,Md.
Jore	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑		1		sition (Name of natory or other pla		Date		ocation - City or T	
Baltimore,			4 □ Donation 5 □ Other (Specify 21. Signature of uneral Service Lice 1)	/1-	Wo		wn Ceme HYPPAdD	- T			nton,Il	
Ba	permit. Departr Importa any Inji		Vaily De	Ledd								g,Md20910
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused ine cause on each lin	the death. e.				ac or respiratory a			Approximate Interval Between Onset and Death
1	/Medical		resulting in death)	a Due to (or as a	a consequer	nce of):	11	1				2 \N/1 N/
	Examiner	<u>.</u>	Sequentially list conditions,	b								
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	a consequer	nce or):						
ĵ.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequer	nce of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d								
	¥ 0,10		IF FEMALE:	230 If you outcome	of programs							
O. Box	The law requires that the death cert to has been signed by the attending age 2 should be detached for use a	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at 9□Unknown	2 ☐ Fetal de	eath 3	Ectopic pregnancy Other (specify)	У			23d. Date of deliv Month	ery Day Year
S,	res that igned b	by Pf	Part II. Other significant conditions co	ntributing to death bu	ıt not resultii	ng in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
or o	w require been sig should t	ted							10	Yes 2[	□ No 3 □ Pro	bably 4 Dunknown
Hecords,	The law cate has be page 2 sh	Completed							24a. Was	psy	prior to co	opsy findings available empletion of cause of
Vital	(0 17		25. Was case referred to medical						1□ Yes	ormed? No	death? 1 ☐ Yes	2 □ No
	yslclan: s certific director,	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2 KER	R/Outpatien	t 3 DOA Oth	or:	eath <i>(Check only c</i> Home 5 $\square$ Resi		6 DOthor (Case	4.0
on or	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Dea 1 1 Natural 5 Pending investigation	28a. Date of Injun (Month, Day	y 28	8b. Time of Injury	28c. Injur		28d. Describe			19)
Division	I or Attend after death. I Director; A d in by the fo	Certification:	3 Suicide 6 Could not be determined	28e. Place of injurbuilding, etc.	ry - At home . (Specify)	e, farm, str			28f. Location ( City or To	Street an wn, State	d Number or Rur )	al Route Number,
ב	pital o		29a. Certifier 12 Certifying Phy	rsician: To the best o	of my knowle	adaa daati	a occurred at the ti	mo data and plac	and due to the			
	ne Hospital of 24 hours af Funeral Die Funeral Dietely filled in	Medical	(Check only one)	iner: On the basis of and manner stat	examination	n and/or in	estigation, in my o	opinion, death occ	curred at the time	, date and	d place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of Certifier				29c. Licens	e number		29d. Dat	e signed (Month,	Day, Year)
	10			1			D5	192	7	Ma	X O7	2007
	, 0		30. Name and address of person who c	ompleted cause of de		_	·	dical (	Tont	D-= -	no Desi	20850
	ր Sta	te	31. Date filed (Month, Day, Year)	32. Pojistra	M r's Signatur	re		urcar (	enter	חב דו	ve KOCK	ville,Md
Γ	Registr	4	MAY 0 9 2	007	us l	4. A	DENE					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 9:45 A M **Physician** May James Edward Young 16 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Great Mills 22190 Baja Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Hours 1 X M 2 □ F 67 218-38-7179 August 27, 1939 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Great Mills St. Mary's Maryland Director 1 ☐ Yes 2X No ns 23a or 28a-f sh must be notified 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 22190 Baja Lane 20634 items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 🔀 No ō 1 ☐ Yes 2 🖾 No Black Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tobacco Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Heatth and Mental Important: If item 27 is marked o any injury or other traumatic eve once. Mary Elizabeth Young Joseph Oscar Holley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) California, MD 20619 Agnes Marie Young / Daughter P.O. Box 896 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 23, 2007 Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 2 ₩6 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑ Natural 5 ☐ Pending investigation Injury s after dea. 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 2017. AVAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2065 Rod Mecha Notch

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day,

MAY 1.8 2007

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 1 | 1 | 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 9, 2007 2:47 PM M Richard W. Bartlett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 7903 Lockney Road Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numberunk 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours May 28, 80 1926 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Evanular must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☐ No Funeral Director Takoma Park MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20912 7903 Lockney Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑XYes 2 □ No If Yes, Give Year or Dates: WWI 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 XDivorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 construction estimator contracting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Bartlett Sara Wilson ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Russell/step son 7092 Pindell School Road Fulton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Bernoval from State 4 □ Donation 5 📉 Other (Specify) in state 21. Signature of Funeral Service Li Ronald S vice Licensee d S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (70n 3 hol wound /Medical Due to (or as a consequence of): S-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred self institute coa 5 Pending investigation 1 Natural 9 2007 1435 1 Yes 2 No may 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, Rd City or Town, State) 7703 Lockney Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Takoma Park, mD 207/2 Home 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

ete has been signed by the atte page 2 should be detached for filled in by the funeral director, this After death. after death within 24 hours a To the Funeral C completely

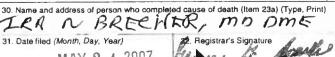
Registrar

Medical

31. Date filed (Month, Day, Year) MAY 2 4 2007

29b. Sonature and title of certification

(Check only one)



rmo DME

29c. License number

29d. Date signed (Month, Day, Year) may 16 2007

1) 00 YES Park Dr 2101 MELICAL Silver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5 Year 01:55 AM William F. Bailey 20 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Square BALTIMORE RANKIN 8. Date of Birth (Month, Day, Year) Aug 26, 19 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthdav) Hours 1**X**] M 2□ F 71 Maryland 1935 213-32-9910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Rosedale Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 USA 8061 Roslyn Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1X1 Yes 2 No 195 If Yes, Give Year or Dates: 195 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1954 1954 1 Never Married 2 Married 1 ☐ Yes 2💢 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Maintenance Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Bailey Bertha Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley Bailey, Wife 8061 Roslyn Avenue Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/23/07 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1-2 W Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

/Medical Examiner P.O. Box 68760 or Vital Records, certificate this To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Division

Examiner ttenoing physician and or use as the burial-transit Physician/Medical signed by the ģ Completed Be 2 Certification:

**Physician** 

/Medical

Examiner

Funeral Director

Be Completed by

ဥ

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mertal Hygiene. Ant. If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

Important: If It any injury or o

Physician

341

Medical

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and Itle of certifier

(Check only one)

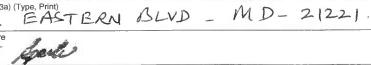


and manner stated.

M.D

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year)

05-23-2007

		For State Registrar	State of Maryland / [	Department of H Certificate of I			ene g. No. 200	7   6807
A		Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
Physic /Medi		MERRIAL BRINKL	EY			MAY	Day Yea 2007	- M
Exami		4a. Facility Name (If not institution, give sta	reet and number)		Location of Death		4c. County of De	eath
·		EMERALD ESTATES AS						
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bii	rthday) If Under 1 Year  Yrs. Months Days	If Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year)	Birthplace (State or Foreign Country)
Director		213-14-3726	85	113.		APRIL 1	11,1922	MD
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
Maryl f sho	ō	MD	BAT.T	IMORE				1 ☐ Yes 2 ☐ No
the 1 28a- notifi	Director	10e. Street and Number	DITE!	10f. Zip Code		10	g. Citizen of What	Country?
with 3a or	Ö	3855 GREENSPRING A	VENIIE	2121	1		USA	
1215-0036 within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral		2. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ar	merican Indian,
Safter a	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 ▼ No	Specify:	nican, etc.)	Black, W	nite, etc.
O3(	by	3 XWidowed 4 ☐ Divorced	Year or Dates:	TEL FES ZENO	Specify.		Specify:	BLACK
21215-0036 of within 72 hours af gigiene. er than "natural", or the Medical Exam	Completed	15. Decedent's Educa (Specify only highest grade		Decedent's Usual Occup	during most of worki		16b. Kind of Busines	ss/Industry
Me ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired	1) -		EDMO A MT	ant.
ygier t	S		5	TEACHER	18. Mother's Name	/Eirot Middle A	EDUCATIO	JN
be fill had out	Be	17. Father's Name (First, Middle, Last)					raiden Surraine)	
Tyla	은	WILLIAM SORRELL	o Crinti 10k	o. Mailing Address (Street		BUTLER	City or Town State	7 Zin Codo)
imore, Maryland 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If tem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type DR. HELENA HICKS/S		000 BOWERS A		IMORE, N		5, 21p 00de)
1 and 1 and Healt em 2		20a. Method of Disposition	20b. Place o	of Disposition (Name of		Date 2	20c. Location - City	or Town, State
ages nt of r or o		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	ery, crematory or other place		507	TAIRDET 1	AADVI AMD
Baltimore, permit. Pages 1 al Department of Hee Important: If Item any Injury or othe once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses		22. Name and Addre	T 1/0		LAUREL, I	ONS F.H., INC.
Baltimo permit. Page Department of Important: If any injury or once.		1 Com 2 A C	morton	1701-31 L				
		23a. Part1, where the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do					Approximate
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/Medical		disease or condition resulting in death)	Due to (or as a consequence		(		_	_
Examiner			401	er tendias				
	je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	Par heart	1			
cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Valon	. Car heart	arker	<i>A</i> .		
O, e exe an ar urial-t	m X	resulting in death) Last	Due to (or as a consequence	of):				
I Records, P.O. Box 68760, ∠ The law requires that the death certificate be executed the has been signed by the attending physician and large 2 should be detached for use as the burial-transit	dical	d.						
c 68 ertifica ing pl	Med	IF FEMALE:						
Box 6 death certific	lan/	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal deat		у		23d. Date of Month	delivery Day Year
the dea	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (specify) _				,
P.(	Phy	Part II. Other significant conditions confi	tributing to death but not resulting	in the underlying cause giv	ren in Part I.	23e. Did tob	pacco use contribute	e to the cause of death?
cords, P.O. w requires that the deben signed by the should be detached	by	Tarrit, Galler algimidant dendinate dent	an bound to do day but not rooming	gg		1 □ Ye	1/	Probably 4 ☐Unknown
require hould	Completed			· · · · · · · · · · · · · · · · · · ·		04 111	/(	
al Rec : The law cate has t	nple					24a. Was au autops perforr	y prior	autopsy findings available to completion of cause of
- 10 -						1□ Yes 2	2 No 1 1 Y	
or Vita Physician: rthis certific	Be	25. Was case referred to medical examiner?	ospital:	utnotiont 3 DOA Oth	26. Place of Deatl			
OF Phys	l L	1 ☐ Yes 2 ☐ No	1 Inpatient 2 EH/O	utpatient 3 DOA	4 Mursing Ho		ence 6 Other (S	Specify)
dling h. After	lio	1 Accident 5 ☐ Pending investigation		Injury Wor	rk?  Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,	
/ision Attending r death. ector: After	fica	3 Suicide 6 Could not be	28e. Place of injury - At home, f	arm, street, factory, office				Rural Route Number,
Division or Vital Records, if or Attending Physician: The law requires the releath.  Director: After this certificate has been signed in by the funeral director, page 2 should be or a fine by the funeral director, page 2 should be or a should be	Certification:	4 Homicide	building, etc. (Specify)			City or Towr	n, State)	
Division or Vita To the Hospital or Attending Physician: within 124 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 12 Certifying Phys	ician: To the best of my knowledg	ge, death occurred at the ti	me, date and place,	and due to the c	ause(s) and manne	r as stated.
n 24 h	Medical	(Check only 2 Medical Examin	er: On the basis of examination a and manner stated.	ind/or investigation, in my	opinion, geath occur	red at the time, d	ate and place, and	gue to the cause(s)
To the I	×	29b. Signature and title of certifier	1/10	29c. Licens	se number 7.10	2	9d. Date signed (M	onth, Day, Year)
		1.1.	VIVV		0000	/	01/	1
i		30. Name and address of person who con	mpleted cause of death (Item 23a)	(Type, Print)	111.1.1	lallin	DOP DI	111.08
,		HIVIN WIS,	ici, qui	va war	1001/10	3040	1019110	0,000
Si Regis	tate trar	31. Date filed (Month, Day, Year)  MAY 2 4 2007	2. Registrar's Signature	Sour )				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2007 Catherine Irene Brown 19, 1:05P May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Franklin Woods Nursing Home Rosedale Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 😾 F 88 Nov. 2, 1918 Maryland Director 216-09-3176 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. If a Medical Evanue for notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21236 8913 Yvonne Avenue Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Electronics 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Margaret McHugh Patrick King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8913 Yvonne Avenue, Baltimore, Maryland 21236 Lester Brown (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) 05/23/2007 Baltimore, Maryland Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Homes, 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROTIC Immediate Cause (Final DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Physician/Medical Examiner the attending physician and ned for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, DEKENTIA 1 ☐ Yes 2 ☐ **X**0 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☑ Ne Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To tha To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4000 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 FRANKLIN SQUARE DR. ARSHALL JIM 31. Date filed (M 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Bland Needra D. May 2007 07 9 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M **2**□F Months 217-84-0684 3-22-1962 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County la or 28a-f show t be notified at 1 ¥Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? USA 21244 8 Cahill Ct "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - Americen Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ XXWidowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Nursing Homes r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 12th grade other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked oth any Injury or other traumatic event once. Unk ၉ Ivory Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 157 Monastery Avenue Balto, MD 21229 Travon Johnson-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5-22-2007 Catonsville, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21 Son tune of Funeral Service Licensee March F/H 4300 Wabash AvenueBalto, MD 21215 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death r ediate Cause (Final ease or condition sulting in death) Physician Severe MEROBINE 1 month /Medical Due to (or as e consequence of): Examiner Sepsis 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d Date of delivery 3 DEctonic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2 400 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ HO ၀ 1 Dimpatient 2 ER/Outpatient 3□ DOA 27. Manne of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 Devonde, MD ATZ438946 19,2007

State Registrar

DHMH 17 Rev 1/2001

MAY 2 4 2007

Mexander

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

@ Unity neurold 201 E University Pankway Solling Not 21218
30 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 3:11 PM **Physician** 20 2007 <u>Clyde Hugh Bedsaul Sr.</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days **™** M 2□F May 28,1924 North Carolina Director 218-18-2320 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Maryland | Harford Forest Hill Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21050 1007 Walters Mill Road Completed by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government 8 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Blanche Green (unk) Bedsaul 2 Willie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1007 Walters Mill Road, Forest Hill, MD 21050 Adam N. Bedsaul / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-22-07 Towson, Maryland Hilltop Service Corp 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service License McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 9 day Physician cances disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner aftending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Inpatient 2 ER/Outpatient 3 DOA 1 Tes After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deal 28c. Injury at Work? Certification: Bedsaul, 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D0053568 Man 20, 2007 500 upper Chesapente 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1eff re filed (Month, Day, 2. Registrar's Signature Year) State 4 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **ALOYSIUS** STOTT BAUER 18, May 2007 12:58 a<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 356 Old Line Avenue Laurel Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days XXM 2□F Hours 579-36-5588 76 22, 1930 Washington, D.C Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 356 Old Line Avenue 20724 USA 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2CXNo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Press Operator Card Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) May Stott Aloysius A. Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Drab Bauer/Wife 356 Old Line Avenue, Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD Veterans Cemetery: 5/23/2007 Crownsville, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD Approximate Interval Between Onset and Death Cardiopulmonary Arrest Due to (or as a consequence of) Morbid Obesity Due to for as a consequence of

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

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Department of H
Important: If Ite
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Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner

and burial-trar the attending I ed by the signed I funeral After he Funeral Director A

The law requires that the death certificate be executed

P.O. Box 68760,62

Division or Vital Records.

Hospital or Attending Physician:

To the the State

Physician/Medical 2 Completed Be 9 Certification: 29a. Certifier 29b. Signature and title of certifier

3 Suicide

4 | Homicide

(Check only one)

6 ☐ Could not be

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2007

30. Na and the ress of purson who completed cause of death (Item 2, a) (Type, Print)

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Baig

31. Date filed (Month, Day, Year)

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Ent.r the disease, or com, fig. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only a cause on each line. Immediate C se (Final disease or condition resulting in death) Sequentially list conditions, it any leading terms (classe. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Non Insulin Dependent Diabetic Due to (or as a consequence of) Hypertension IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Gout 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ※☐ No 24a. Was an autopsy performe 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **XX**Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 21, 2007

DHMH 17 Rev 1/2001

Registrar

Avenue,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0013689

Laurel, MD 20707

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

- O41

Baltimore

32 Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Berwyn G. Bender, Sr. 8:05 2007 May 17, A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 144 Park Rd Pasadena If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 6, 1934 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ xM 2 □ F 73 May 6, **Director** 335-26-4233 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Exercited 2006. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2□No Directo Pasadena Anne Arundel MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21122 USA 144 Park Rd 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2kkNo Specify Specify: þ White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Sales Executive 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances K. Stelmach ပ္ Atwood G. Bender 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 144 Park Rd, Pasadena, MD 21122 Rose Marie Bender 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1xxBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery May 23, 2007 Brooklyn, MD 21. Signature of Funeral Service I 22. Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S, Glen Burnie, 23a. Part1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ones a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy fo Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed Records, P.O. Box 68760, 名 Division or Vital

To the Hospital or Attending Physician: within 24 hours at er death. within 24 hours are death

To the Funeral Director

completely filled in by the

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3 ☐ Suicide

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be

determined

1650 ORLEANS ST, BALTIMORF, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

10

Medical

07-03710 Charles Brizzi

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 | 6813

	Re	For State		Ce	ertificate c	of Death				Reg. No.			
Physician/	1.	Decedent's Name (First, Midd	le,Last)						2. Date of De Month	Day	Year	3. Time 0	
d Examine		Charles		Brizzi_		4b. City, Town		an of Doot	Month May 14,	2007	ounty of D		
	48	a. Facility Name (if not institution Sinai Hospital	n, give street and n	umber)		Baltimor		on or Dear	"	10.0	ounty or E	· Cuti	
	Ļ		6. Sex	7 Ago (In yes	. last birthday)	If Under 1		Jnder 24Hr	s. 8. Date of I	Birth (MM/DE	)/YYYY) 9	i. Birthplace (S	tate or
Funeral Director	5.	. Social Security Number				Months		ours Mi	n.		F	oreian	I
Director	L	217-42-2406	1X M 2 F	6	0 Y	rs.			Feb.	16, 1	94/	Country)F1	orida
any	_	sual Residence of Decedent  0a. State 10b. County		10c. Ci	ty, Town or Loc	ation						10d. Insi	de City Limits
* .	1.				D., 1 + -	_						1XXY	es 2 No
faryland 28a-f show 1 at ouce.	ξ  <sub>-</sub> ,	MD Howa:  Oe. Street and Number	ra		Fulto	10f. Zip Co	ie			10g. Citize	n of What	Country?	
the Maryland or 28a-f sh iffied at once	<u> </u>												
ith the M 23a or 2 notified		8237 Reservo: 1. Marital Status	ir Road	ecedent Ever in	U.S. 13. V	Vas Decedent o	0759 f Hispanic	Origin? (	Specify Yes or			American India	n, Black,
r death with or items 23 must be no	<u>.</u>	Never Married 2 XX	Married Armed	Forces?	If	Yes, specify C	uban, Mex	ican, Puer	to Rican, etc.)		White, e	etc.	D
		3 Widowed 4 Di	1 Yes		1	Yes 2 X X	No spe	cify:		S	pecify: [	White	
urs aft tural" amine	<u> </u>	15. Decedent's Education (Spe	or Dates:		16a. Deced	ent's Usual Oct most of working				16b. Kir	nd of Busin	ness/Industry	9.11
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami		Elementary/Secondary (0-12	) College	(1-4 or 5+)	during	most of working	ille. DO I	NOT USE IS	stired)				Supply
036 ithin ne. refis	힐	12th	4		Own	er				Br	izzi	Billia	Supply rds
Hed within Hygiene.		7. Father's Name (First, Middle	e, Last)				18.Mo		ne (First, Middl	e, maiden o	urname)		
121 Id be fil tental I narked event,	8	Joseph Cara	stro, Jr.		1400 14-0	ing Address (		Edi	th John	ISON	or Town	State Zin Cod	(e)
	2 1	9a. Informant's Name/Relation											·,
C 60 - C	L	Carol A. Bris	zzi/Wife_	20	b. Place of Disp	Reserv			Date	20c. Lo	cation - C	ity or Town, St	ate
	1	1 Burial 2 X Crematic	on 3 Removal	from State	crematory or	other place)			/ /				
Page ment or ot	L	4 Donation 5 Other	Specify:	W	est Aru	ndel Cr				1	nton		
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	2	21. Signature of Funeral Service	e Licensee	N) M01				D	onaldso			Home, 0707	P.A.
	-	23a. Part I, Énter the disease, o	or complications that	M01 caused the de	ath. Do not ente	13 Talk	ying, such	as cardia	or respiratory	arrest, shoo		Appro	ximate Interval
nysician Medical		failure. List only one caus	se on each line.	iac tampo								Betwe	een Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		s a consequence				-					
		Sequentially list conditions,	ь. Right	ventric	ular perf	oration							
Š	<u>i</u> je	if any, leading to immediate cause. Enter Underlying Caus		s a consequenc	e of):							A	
\$	ΕΙ	(Disease or injury that initiated events resulting in death) Last	C	s a consequenc	ce of):			_					
760, sicate be executed physician and the burial - transit		events resolving in assuring ass	d										
760, cate be executed physician and the burnal - trans	Medical	Xunpended	AMENDE	-b.27.28	a-f, perM	E. 2868.	6/13/0	07 TT					·
760, icate be physic the bur	ĕ⊨	IF FEMALE:	23c. If ye	s, outcome of p	regnancy						. Date of d		Year
687 ertific ertific ertific	cian/	3b. Was decedent pregnant in past 12 months?		e birth egnant at time o	( L	Fetal death		ctopic pre	gnancy		Month	Day	rear
Box 68 e death certif the attending	S	1 Yes 2 No 9 U	Internation	known	or death 5	Other (Specif)				4			
Records, P.O. Box 681  The law requires that the death certificate has been signed by the attending page 2 should be detached for use as the control of the	됩	Part II. Other significant cond	ditions contribution	g to death but n	ot resulting in th	ne underlying ca	use given	in Part I.				ute to the caus	
P.C	<u>ā</u>								1_	Yes 2	No 3	Probably 4	<b>✓</b> Unknown
ds,	ompleted									Vas an utopsy	24b. W	ere autopsy fir	ndings available on of cause of
COr law last has t	립								_ \p	erformed? es 2 No	de	eath? ✓ Yes	2 No
Reifficate	ပြ	25. Was case referred to medi	cal			26	Place of D	Death (Che	ck only one)				<u> </u>
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  The after death.  The tal pirector: After this certificate has been signed by the funeral director, page 2 should be detach.	<u>ا</u> ۵۵	examiner?		Inpatient 2	ER/Outpat	ient 3 DO	A Othe	er <sub>4</sub> Nu	rsing Home 5	Reside	nce 6	Other:	
of V g Physical dieral d	앍	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	ate of Injury	28b. Time		c. Injury at		28d. Desci	ibe how inju	ry occurre	ed	
nding th.	틸		ending May	onth, Day, Year) 14, 2007	unk	Ì	1 Yes	2 XNo	Therape	eutic m	isadve	enture	
isic	iga				At home, farm, s	street, factory, o	ffice buildi	ing, etc.					te Number, City
Divis	Certification:		etermined (Spec	ify) ope	ration Ro	om			Sinai	Hospit	<u>al, Ba</u>	ltimore,	MD
Division of Vital Records, P.O. Box 68.  To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deaded for use as	a C	29a. Certifier 1 Certifying	Physician: To the	best of my know	wledge, death o	ccurred at the ti	me, date a	ind place,	and due to the	cause(s) an	d manner	as stated.	v(e)
To the within To the comple	Medical	one) 2 Medical E	xaminer:On the bas	sis of examinati er stated.	on and/or inves				ed at the time, t				
F > F 3	žΪ	29b. Signature and title of cert	ifier	1			icense nu			1		ed (Month, Da <sub>)</sub>	y, rear <i>)</i>
		Calille	LUD	1	1		O.C.M.E			ivia	/ 15, 20		
	t	30. Name and address of pers				enn Street	Paltima	ore MD	21201				
Ø		Zabiullah Ali, M.D.	Assistant Me	Registrar's Sig		enn street	parumo	JIE, IVID	21201				
Sta Registr		31. Date filed (Month, Day, Yea		ricegistral's SI		and)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 20, **Physician** 2007 1:55 p<sup>M</sup> Julie Anna Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ivy Hall Nursing Home Middle River Baltimore 8. Date of Birth (Month, Day, Yea May 11, 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕌 F Maryland Ï924 83 218-18-0330 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2□No MD Dunda1k Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21222 USA 3432 Cornwall Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 ☐ Widowed 4 € Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) lith and Mental Hygiene. 27 is marked other than " r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Key Punch Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Woiz Henry Adler ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3805 Byxbee Road Randallstown, MD 21133 Theresa N. Beggs- Niece Health tem 27 i Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If It
any injury or o
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/23/07 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S Zeiler & Son 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 23a. Part Lanter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma Rectal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 5 Pending investigation 1 🔲 Yes 2 □ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director: within 24 hours a

3□ Suicide 4□ Homicide	6 Could not be determined	28e. Place of in building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office	28f. Location (Street and Number or Rural Route Num City or Town, State)					
29a. Certifier (Check only one)			of examination and/or	eath occurred at the time, date and place r investigation, in my opinion, death occu						
29b. Signature and		•		29c. License number	29d. Date signed	(Month, Day, Year)				
* Ch		so,	MD	D00 6190	-	107				
30. Harne and addr	ress of person who cor	mpleted cause of	death (Item 23a) (Type 112 4	lace Avenue,	Baltimore	MD 21221				

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 2 4 2007

hukwuma

6 ☐ Could not be



			1 - For State Registrar	State of M	laryland		artmen rtificat					jiene	007	16	815
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year		of Death
	Physici /Medio		DAVID CHI	SHOLM	SR.						MAY	23	2007	12:	05 MM
	Examin		4a. Facility Name (If not institution,	ive street and number,	)		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	-1	
1			UNIVERSITY OFMI	TRYLAND ME	OICAL	L CENTER	1	3A11	Imok				N/	A	
	Funeral		5. Social Security Number 6	. Sex 7. A	ge (In yrs. la		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day JUN 10	Year)	9. Birthp	place (State	e or Foreign
	Director		024-05-6847	1 <b>X</b> M 2□F	90	Yrs.	NOTITIES	Days	riodis	Will I.	JUN 10	1916	Irel	and	
	D .		Usual Residence of Decedent  10a. State 10b. County		10a City	Town or Lo									05. 15
	aryla shor	<u>-</u>													City Limits  s 21 No
	Ba-f	acto	MD Balti	nore	Cat	onsvi									
	vith th	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizen	of What Cour	ntry?	
	ath v	ra	707 Maiden Choi					228					SA		
	er de	une	11. Marital Status	12. Was Decedent Armed Forces	?	. 13.	Was Deced If Yes, spec	lent of Hi cify Cubai	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,		
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Medical Egatriner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 StYes 2 ☐ If Yes, Give Year or Dates:	10 1	5	1□Yes :	2[ <b>X</b> No	Specity:			Spe	city: Wh	ite	
윽	hou		15. Decedent's			16a. Dece	dent's Usua	al Occupa	ntion		1	16b Kind o	f Business/In		
5	n 72	Completed	(Specify only highest	grade completed)		(Give	kind of wor	rk done o	turing mos.	t of worki	ng	TOD. THE O	. 2001110000111	dustry	
7	within liene.	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Comp	osito	r				Print	ina		
D	e filed within al Hygiene. I other than '	BeC	17. Father's Name (First, Middle, La	st)		Jon.p.	00100	-	18. Mothe	er's Name	(First, Middle,				
au	lid be lental ked c	To B	David Chisholm						Eliza	beth	Demp	ster			
Maryland 21215-0036	should and Me mark umatic		19a. Informant's Name/Relationship			19b. Mailir	ng Address				I Route Number		wn, State, Zip	Code)	
	ges 1 and 2 should it of Health and Men if Item 27 is marke or other treumatic		David S. Chishol	n, Jr sc	n	1 She	eila <i>i</i>	Aveni	ue, W	lobur	n, MA	01801			
Baltimore,	of Heal		20a. Method of Disposition		rar	ce of Dispo	sition (Nan	ne of ther place	p)	С	Date	20c. Locatio	on - City or To	own, State	
Ĕ	permit. Peges Department of h Important: if tte any njury or of		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		)	ro Cre	•	•	,	126/	2007	Raltin	nore, N	νſΓ	
ä	mit. Pe partmen sortant: / njury	-	21. Signature et Funeral Service Lic	ensee N. Willi		22	Name ap	d Addres	s of Facilit	y_1 T	2007	A	iore, i	1111/	
Ö	Dep in pe		> Sign	Thin The	ams		301 1	abb i Frede	uner	ат н	ome, P. d, Cator	A. nevill	o MD	212	28
	_		23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cause	d the death.	Do not ent	er the mod	e of dying	, such as	cardiac o	or respiratory arr	est,	E, 1117	Approxim Interval B	ate
8	Physician		Immediate Cause (Final		DNGE	- T. 11	- H	-207	- En	11.	a .—	K	4	Onset an	d Death
	/Medical		disease or condition resulting in death)	Due to (or as			2 // 0	MILI	/- /7	rure		113	XX		
М	Examiner		Conservation that are affiliated	A	ORTIC	57	ENUS	15			A	. VV U	VVa	40	96
		ner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):			0	1	The As	The State of	En		
3	cuted nd ransl	Examiner	that initiated events	c. HEA	DING	TURY	WIT	1+ 1	3160	IN	D BY ME	DICK		400	15
Ó	te be executed ysiclen and ie burial-transit		resulting in death) Last	Due to (or as		nce of).			AA	MA	NEGALIE				
8760,		Ical		d. 171	1		_		_ [V]:	CATION				40A	45
Division of Vital Records, P.O. Box 68	Physician: The law requires that the death certifica this centificate has been signed by the ettending phral director, page 2 should be deteched for use as the	by Physician/Med	IF FEMALE:			-				_			-		
ရွိ	ath co	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal c	leath 3	Ectopic pr	egnancy				1	Date of delive Month	Day	Year
<u>.</u>	the e	Sic	1 Yes 2 No	4□Pregnant a 9□ Unknown	it time of dea	ith 5□	Other (sp	ecity)					Wichter	Day	1001
<u>~</u>	hat the d by detect	Ph	Part II. Other significant condition:	contributing to death I	out not cocult	ing in the			n in Dard I		22a Did tol				f death?
Ś	signe I be d		DYSPHAGIA	recontributing to death t	2011101103011	ang in tale di	ildenying G	ause give	nin rani.	•		es 2 No	ontribute to the		Unknown
9	requ	etec	^ '									95 ZIMINO		ably 4	JOHKHOWH
ec	e 2 s	Completed	PUNCTATE IN	TRACERER	BRALI	temo	RRHAC	15			24a. Was a autops	v	<ul> <li>b. Were auto prior to cor</li> </ul>	psy finding mpletion of	s available cause of
<u></u>	: The	S									perform 1 ☐ Yes	ned? 200 No	death? 1 ☐ Yes	2□ No	
ij	ician sertifi ector	Be	25. Was case referred to medical examiner?	Hannitati (A. 4)				1		of Death	Check only on	θ)			
ot	Phys this al dir	2	17 Yes 2 No	Hospital: 1 VInpati		R/Outpatier		-	40110		ne 5 🗆 Reside			y)	
L C	ling After funer	lo	27. Manner of Death 1 □Natural 5 □ Pending	28a. Die of Inju (Month, Da	y Year)	8b. Time of Injury		8c. Injury Work	?		28d. Describe ho				
<u></u>	death death stor:	lcat	2 Accident investigat 3 Suicide 6 Could not	be One Diese of In	_	# M	M		′es 2.∭7		I-ELL F				
<u>≥</u>	or A efter Direct in by	Certification:	4 Homicide determine	building, et	tc. (Specify)	ie, rarm, str	eet, ractory	, опісе		1	28f. Location (SI City or Town 707 MAID	n, State)	m <i>oer</i> or Hura	CAT	moer, English
_	pital ours ours illed		29a. Certifier 1 Certifying	Physician: To the best	of my knowl	edge door	Occurred .	at the time	o date a-	d place	and due to the	EN CHO	ICE LAN	E I	no,
	To the Hospital or Attending Physicien: The law within 24 bours effect death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	of examinatio	n and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time, d	ate and plac	manner as si e, and due to	the cause	(s)
	omple	Me	29b. Signature and title of certifier				29c	. License	number		2	9d. Date sig	ned (Month,	Day, Year)	
	. > = 0		D 0/	MD				142	52			in o. i	23 7	007	
	الا		30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Tyne	Print)	100	ے د			ring	-3,2		
	10 41		N I	LAND 22	4. (	REE	NIE <	T.	BOIT	no	LE, MI	). 2	1201		
	Sta	te	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu	re	· i								
	Registr	ar	MAY 2 4	2007 Jane	5 SS.	140	MOL)								

			FOR	partment of Health and Menta ertificate of Death	al Hygiene 007 16816
14	n Wa		Decedent's Name (First, Middle, Last)	2. Dat	te of Death 3. Time of Death
4	Physicia		Marie J. Colangelo	May	M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Examilia	er ,	8811 Dearborn Drive	Nottingham	Baltimore
-	Funeral	~	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		te of Birth (State or Foreign Country)  9. Birthplace (State or Foreign Country)
14	Director		213-16-0486 <sup>1□ M 2</sup> F 86 Yrs.	Months Days Hours Min. (Mo	ch 11,1921 Maryland
	<u>u</u>		Usual Residence of Decedent		•
	iryłar show	_	10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limits 1 ☐ Yes 2♥ No
	Be-f	cto	Maryland Baltimore	Nottingham	
	or 2	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath v		8811 Dearborn Drive	21236	U. S. A. as or No- 14. Race - American Indian,
	er de Item	Funerai	Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	etc.) Black, White, etc.
36	4 within 72 hours after death with the Maryland Jiene. Ir than "natural", or Hems 23s or 28e-f show the Madical Examinar must be nailffed at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White
21215-0036	tura tura	ed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
15	in 72 n "nat	Completed	(Specify only highest grade completed) (Giv	re kind of work done during most of working DO NOT use retired)	
212	d within plene. r than " th Me	Eo		Office Clerk	General Office
	be filed Ital Hygi od other event, t	0	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)
<u>la</u>		To B	Joseph dekowski	Julia k	Kiper
Maryland	s 1 and 2 should f Health and Mer flem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rural Route	B Number, City or Town, State, Zip Code)
	and lealth m 27		TOTAL DE DOMESTO COMMITTO		ingham, Maryland 21236
ore	00 = =		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State	position (Name of ematory or other place) Valley Mem.	20c. Location - City or Town, State
Baltimore,	Pa nen ent: ury		4 Donation 5 Other (Specify) Entombment Gardens	Mausoleum 05/25/20	
3all	permit. Departr Importe any inj			22. Name and Address of Facility Schimu	
	20 = a a			9705 Belair Road, Balt	
1			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one dause on each line.	nter the mode or dying, sucryas cardiac or respi	ratory arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Finaf disease or condition resulting in death)	seway Tech	Cent one month
	/Medical Examiner		pue to (or as a consequence of):		110000
		-	Sequential, list conditions b. ue tr (o as a nsequence f):	48202	greens
	ted nsit	nju	cause. Enter Underlying Cause (Disease or injury	Tide MIG	Terine
	be executed sicien and burial-transit	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):	Si a contesc	10013
8760,	cate be executed physicien and the burial-transit	dicai	· ·		
89		0			
Вох	eath certific attending p for use as	N	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy	23d. Date of delivery
	death e atte	cia	in the past 12 months?  4 Pregnant at time of death	Cher (specify)	Month Day Year
P.0	at the de by the a	Physician/M	9 □ Unknown		
	The law requires that the death certifi ste has been signed by the attending cage 2 should be detached for use a	by F	Part II. Ot es in nificant conditions contributing to death but not resulting in the	underly un cause given in Part I. 23	3e. Did tobacco use contribute to the cause of death?
Records,	w require been signshould b		Longing Opplyday	se farminains	1 Yes 2 No 3 Prebably 4 Unknown
ec.	law r as be 2 sh	Completed	Uysphasja	\ 415Ave 24	4a. Was an autopsy findings available prior to completion of cause of
<u> </u>		Con	1 / 0	10	performed? death? ☐ Yes 2☐ No 1 ☐ Yes 2 ☐ No
Vital	iclan: T certificat rector, p	Be (	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)
of <	Physiclan: r this certific ral director,	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		Residence 6 Other (Specify)
	in in in in in in in in in in in in in i	on:	27. Manner of Death 28a. Date of fnjury 28b. Time (Month, Day Year) Injury Injury	Work?	escribe how injury occurred
Si	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury 4t home farm	M 1 Yes 2 No	cation (Street and Number or Rural Route Number,
Division	or Al after of Direction by	ertification:	4. Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		ty or Town, State)
_	spital ours ours a nerel filled	CK	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and du	e to the cause(s) and manner as stated.
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	(Check only 2 Medical Examinat: On the basis of examination and/or and manner stated.		
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	4		Lun Cexceus	MANDON AND	FOOT HE PAM 9
	8		30. Name and address of person who completed cause of teath (ftem 28a) (Typ	e, Print)	
	U		Dr. Michael Zang, Overlea Physician	s, 7602 Belair Rd., Ba	altimore, Md. 21236
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Davis	
100	Registi	ar		F-1	

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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En C	1 8			and the	à

ysician	dle 1-	State of Maryland / Department -For State Certificate	of Death	Reg. No.	
		tegistrar 1. Decedent's Name (First, Middle,Last)	2. Date o	Day Yea	3. Time of Death 0742 hrs
xamine	er:	Kimberly Joan Cadle		19, 2007 4c. County of	
	4	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death  East New Market	Dorches	
		3680 Warwick Road  5 Social Security Number 6. Sex 7. Age (In yrs. last birthday		of Birth (MM/DD/YYY)	9. Birthplace (State or
neral	- 1	o. dodia dodany visit	Months Days Hours Min. 05-	27-1967	Foreig Maryland
ector		217-88-0467 1_M 2XF 39	Yrs.		
		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limit
w any		Pol A			1 Yes 2 X N
f sho	اڌ	Maryland Harford Bel A  10e. Street and Number	10f. Zip Code	10g. Citizen of W	hat Country?
Mental Hygiene marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at ouce	<u>1</u>		21014	U.S.A	•
or items 23a or 28a-f show must be notified at ouce.	Funeral Director	307 Fulford Avenue  11. Marital Status  12. Was Decedent Ever in U.S.  13. Marital Status	Was Decedent of Hispanic Origin? ( Specify Yes		e - American Indian, Black, te, etc.
tems st be	ner	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, e	(C.)	
, or i		2 Widowod 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify.	
'natural", Examiner	힐	Tor Dates.	cedent's Usual Occupation (Give kind of work don- ing most of working life. DO NOT use retired)	e 16b. Kind of b	Business/Industry
d Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Della	Roses Restaura
Aygiene other than ' the Medical	ldu		2p Cook 18.Mother's Name (First, M		
Tygie other the N		17. Father's Name (First, Middle, Last)	Patricia Mi		
Mental Hygiene marked other than "natural e event, the Medical Examin	Be	William R. Roberts  19a. Informant's Name/Relationship (Type, Print )  19b. (	Mailing Address (Street and Number or Rural Ro	oute Number, City or To	own, State, Zip Code)
is m	2	19a. Informatics Name / Classics in (1) per	Fulford Ave Bel Air,	MD 21014	
nt of Health and Mental F t: If item 27 is marked other traumatic event,		Charles L. Caule (120b. Place of	Disposition (Name of cemetery, Date	20c. Locatio	n - City or Town, State
of He		1 X Burial 2 Cremation 3 Removal from State	y or other place) Memorial 05-24-20	007   Bel A	ir, Maryland
ment of H tant: 1f i		4 Donation 5 Other Specify: BEL ATT	22 Name and Address of Facility C - 1- 4	nok Funeral	Home of Bel At
Department of Important; injury or otl		1 10 - 6 1 4 0 0 4	Inc 610 W. MacPhail	Rd Bel Air	, MD 21014
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac or respir	atory arrest, shock, or	Between Onset a
sician ledical		failure. List only one cause on each line.	cation complicated by liver o		Death
aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	ner	Due to for as a consequence of			
	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
e be executed ysician and burial - transit	ŭ	d			
executed ian and ial - transi	edical	XUNPENDED AMENDED 47,28a-f. peri	ME. 9869 7/13/07 TT	Test Bat	- of delivery
ate be ohysici ne buri	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Dat Mont	e of delivery th Day Year
leath certificate e attending phys for use as the b	Sician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Pregnant at time of death 5	Total document		
eath c atten for us	Sign	1 Yes 2 No 9 V Unknown 9 Unknown			in the transport doubt
the d by the ached	1 4	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		ontribute to the cause of death
res that signed   I be deta	2				4b. Were autopsy findings ava
require been si hould b	١			autopsy	prior to completion of caus-
v v d s	2 2		1	performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 N
lar has		25. Was case referred to medical	26.Place of Death (Check only of		
The lav ficate hav , page 2 s	á	examiner? Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other Nursing Ho		6 🗸 Other: Scene
ician: The law s certificate has rector, page 2 s	1	197 Manner of Death	Timo or myery	Describe how injury o	to metabolize
Physician: The law er this certificate has aral director, page 2 :		(Month, Day, Year)	I I IES Z VINO	-	ications Number of Rural Route Number
nding Physician: The law th. :: After this certificate has e funeral director, page 2 3				Location (Street and I	Jumber of Rural Route Number
Attending Physician: The law rr death. cretor: After this certificate has by the funeral director, page 2:		2 X Accident Investigation Unk 28e. Place of Injury - At home, f	ailii, stroct, laotor), since come	or Town, State)	
al or Attending Physician: The law is after death.  al Director: After this certificate has led in by the funeral director, page 2 !		2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify) residence	3	or Town, State) 680 Warwick F	Rd East New Market
Hospital or Attending Physician: The lav 4 hours after death. Suneral Dircctor: After this certificate has	y miled in by an	2 X Accident Investigation  3 Suicide 6 Could not be determined (Specify) residence  4 Homicide (Specify) residence	3	or Town, State) 680 Warwick F	Rd Fast New Market
in the Hospital or Attending Physician: The lavifin 24 hours after death. The Functor: After this certificate has the Functor: After this certificate has malerely filled in by the funeral director, page 2.	y miled in by an		path occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	or Town, State) 680 Warwick F to the cause(s) and me time, date and place,	Rd Fast New Market anner as stated. and due to the cause(s)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Divector: After this certificate has commletely filled in by the funeral director, page 2.	y miled in by an	(Check only one)    Certifying Physician: 10 the best of thy knowledge, defining the property of the past of the basis of examination and/or	eath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the 29c. License number	or Town, State) 680 Warwick F to the cause(s) and me time, date and place, 29d. Date	Rd Fast New Market anner as stated. and due to the cause(s) e signed (Month, Day, Year)
tending Physicath.  or: After this the funeral dir	y miled in by an		path occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	or Town, State) 680 Warwick F to the cause(s) and me time, date and place, 29d. Date	Rd Fast New Market anner as stated. and due to the cause(s)
To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	y miled in by an	Certifying Physician: To the best of the house of examination and/or and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a)	eath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the 29c. License number O.C.M.E.	or Town, State) 680 Warwick F to the cause(s) and m time, date and place, 29d. Date May 20	Rd Fast New Market anner as stated. and due to the cause(s) e signed (Month, Day, Year)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has committeely filled in by the funeral director, page 23	y miled in by an	Certifying Physician: 10 the best of the house of examination and/or and manner stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	eath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the 29c. License number	or Town, State) 680 Warwick F to the cause(s) and m time, date and place, 29d. Date May 20	Rd Fast New Market anner as stated. and due to the cause(s) e signed (Month, Day, Year)
7	y miled in by an	29b. Signature and title of certifying Physician: To the best of the host of the host of examination and/or and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	eath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the 29c. License number O.C.M.E.	or Town, State) 680 Warwick F to the cause(s) and m time, date and place, 29d. Date May 20	Rd Fast New Market anner as stated. and due to the cause(s) e signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No, 1. Decedent's Name (First, Middle, Last) **Physician** Frank M. Carter Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINIDALE Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 DC 8. Date of Birth **Funeral** Months Days Hours 7/13/1930 212-28-5158 1 XM 2 ☐ F 76 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "neturel", or Items 23a or 28a-f show Idical Examiner must be notifled at MD Anne Arundel Linthicum Director 1 ☐ Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 208 Nursery Road 21090 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ White Specify: 3 Widowed 4 Divorced Completed other than "netu 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Equipment Operator College (1-4or 5+) Equipment Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is merked of Metcalf Carter Marjorie Howottnick 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra Mrs. Mary Carter/wife 208 Nursery Rd., Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Cemetery 5/23/2007 Glen Burnie, MD 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner STAGE RENITL END DIS EASE Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Kana certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery that the death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CORONARI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No BRTERI 24a. Was an has autopsy The this certificate 1□ Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 XInpatient Other: 1 Yes 2 No မ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) vithin 24 hours
the Funeral Dires
to filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20063327 05/21/2007 Carry H. Wornstatewor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 WO BELVEDERE AVE, BALTIMORE, MD 21215 WOLDEHINOT,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOAN LOUISE CARR 17 2007 9:52  $\mathbf{P}^{\mathsf{M}}$ MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 F 134-24-2846 Yrs. Director 75 Sept. 30 1931 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show Examiner must be notified at Director 1 Yes 2 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Main Street, #334 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married or. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Cocupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Self Storage Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H 7 is marked otl Be Oscar Kritsberg Viola DOOM 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Robert L. Carr / Husband 501 Main Street, #334, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any injury or conce, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 15/21/2007 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee (M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. E f the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cau in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Septic Shock 7 Hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Gram Negative Bacteria Sequentially list conditions, if any leading 1 cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) that the death certificate be executed physician and is the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🏋 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Acute/Chronic Malnutrition 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Completed Occlusive Peripheral Arterial Disease 24a. Was an autopsy performs Were autopsy findings available prior to completion of cause of Pulmonary Congestion 2 XNo 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 2 X ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Box 68760, o Records, or Vital Division Hospital or Attending within 24 hours at To the Funeral

> 5 State

Registrar

Rene L. Gelber, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

COURN MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D17502 29d. Date signed (Month, Day, Year) 18, 2007

14201 Laurel Park Drive, Laurel, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signature

2007

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Montr 05 2<sup>Day</sup> 2007 Anna Catherine Carrigan 02:10 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Ruxton Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 05/13/1917 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗙 F Maryland 217-05-5985 90 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 Taylor Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White by 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker cup manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar C. Duke Clara B. McElwain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wells, Daughter 3113 Woodhome Rd. Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 05/25/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Donandias 5305 Harford Rd. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ND STAGE DEM ENTIA **Physician** disease or condition resulting in death) cos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes S No Hospital: Other: 4 Nursing Home ို 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes filled in by the fu 2 🗌 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i Text Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 05/21 200

Registrar

State

30. Name and address of person who completed c

Kendall

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Sueta 204/

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Faulkier MD/6565N. Charles St

			1 - For State Registrar	State of Ma		epartmer <i>Certificat</i>				giene Reg. No.	007	16821
	Physici /Medic		1. Decedent's Name (First, Middle, La.  Edward F. Dice J:	,					2. Date of De Month May 12	Day	Year	3. Time of Death  1:30 PM M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City,	Town, or Los	cation of Death			unty of Oeath	
			2065 Corbett Road		//a		kton	Hadar 24 Hrs	La But at Bill		altimo	
	Funeral Director		217-22-4030	ex 7. Age	(In yrs. last birt	Months		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da Apr 22,	y, Year)	9. Birthi Coul Mary	place (State or Foreign ntry) 1and
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary In the	to	MD Baltim	ore	N	Monkton						1 ☐ Yes 2X No
	n the	Director	10e. Street and Number			10f. Zig	Code			10g. Citizen	of What Cou	ntry?
	th wit		2065 Corbett Roa	d			2111	.1			USA	
0000	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural, or iteme 23s or 28s-f show other treumatic event, the Modical Examinar mast be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		nic Origin? (S lexican, Puerl pecify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ec <i>ify:</i> whi	etc.
5	2 hou		15. Decedent's Ed	lucation		Decedent's Usu	al Occupation	1 , ,		16b. Kind	of Business/In	dustry
<u>'</u>	thin 7	Completed	(Specify only highest gra	College (1-4or 5+	-)	(Give kind of wo life. DO NOT u	rk done durir se retired)	ng most of wor	king			
7	led wi lygien her th		12	4		safe	ty dir			Ger	neral M	lotors
	i be fi	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nan	ne (First, Middle,	Maiden Sur	name)	
Ž	houtd Id Mei mark	၉	Edward Freed Dice		19h	Mailing Address	L (Street and	ouise	Caroline	Bas1	er -	Code
<u>8</u>	ulth and 2 s		Kathryn Arnold/da	•								(Code)
more,	permit. Pages 1 an Department of Heel Important: If Item 2 eny injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Total (Specific	9	20b. Place of	Disposition (Nai	ne of	ac mone	ton, MD	2111 20c. Locati	on - City or To	own, State
	permit. Departmitmporta eny inju		21. Signatur of Funeral Serice Licen		ctor	State Baltimo	Address of	y Board	1 655 W.	Balti	more S	treet
П			23a. Part . Enter the disease, or com- shoot, or heart failure. List only	plications that caused to	the death. Do n	ot enter the mod	le of dying, su	uch as cardiac	or respiratory ar	rest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition			11:00	716	Itina	7 1)150			Onset and Death
	/Medical		resulting in death)		consequence o		116	116172	13130	- 1+SC-		3
	Examiner	_	Sequentially list conditions,	b								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	f):						
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence o	l):						
0070	ficate be executed physicien and s the burial-transit	aiE	· ·	d .		,						
0	ifficate g phy as the	edicai	_	d								
O. DO.	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funneri effector: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 ⊟Ectopic pr 5 ⊟ Other (sp				23d.	Date of delive Month	ery Day Year
Ĺ,	that hed by deta		Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying o	ause given in	Part I.	23e. Did to	bacco use o	contribute to the	ne cause of death?
2 .	quires on sign	ed by	CORONAR	1 ARTE1	24 13	SEAS	6		1 🗆 Y	′es 2 □ N	o 3 Prob	ably 4 Unknown
ב נ	awre is bee 2 sho	plet			(				24a. Was		b. Were auto	psy findings available
	The I	Completed								rmed? 2 No	death?	mpletion of cause ol
2 .	cien: artific actor.	Be	25. Was case relerred to medical examiner?				26.	Place of Dea	th (Check only o			
5	hysia this can dire	၉	1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatient				Nursing H	ome 5 KResid			y)
	ending F sath. or: Alter he funer	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation			me of jury M	8c. Injury at Work? 1  Yes	2 🗆 No	28d. Describe h	iow injury oc	curred	
	tel or Att rs efter de el Direct led in by t	0	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fari (Specify)	m, street, factory	r, office		28l. Location (S City or Tow	Street and Nu m, State)	umber or Rura	l Route Number,
	in 24 hours in 24 hours in 6 Fune pletely fil	edicai	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of liner: On the basis of e and manner state	examination and	death occurred /or investigation	at the time, d , in my opinio	ate and place, n, death occur	and due to the c red at the time, o	cause(s) and date and pla	manner as si ce, and due to	ated. the cause(s)
	To To	Σ	29b. Signature and title of certifier				. License nur				gned (Month,	
			) small		mo		Doos	5229	2_	5//	7/200	7
			30. Name and address of person who of				0 12 10	1	11		100/3	21.00
	Sta	ie.	31. Date liled (Month, Day, Year)	32. Registrar	's Signature		CO 1413	Lut	(ACTE VI	LLL	17(1)	21093
	Registra		MAY 2 4 200		337 1	OBACA .						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Edward Millard Daniels, Jr.	State of Maryland / Department of Health
Edward Millard Darliels, or.	Otato of Marjantan = 1

Ward William -		For State	-	Certifi	cate of I	Death					Reg. No.		12	Time of Death
1ysicia	_	egistrar . Decedent's Name (First, Middle,Las	t)						2. Da	ate of De onth ay 21,	Day	Year		0900 hrs
ر Exami	ner	Edward M. Danie	1s, Jr						Nic.	ay 21,	2007	. County o	f Death	
	4	a. Facility Name (if not institution, giv	e street and number)		- 4t	. City, Town		cation of L	Jeath			Baltimore		v
	ш.	3029 Parktowne Road				Parkville					1			lace (State or
E	f	. Social Security Number 6. Se	9x 7. Age (I	n yrs. last t	birthday)	If Under 1	_	If Under 2					Foreign	_
Funeral Director	- 1		M 2 F	51	Yrs.	Months	Days	Hours	Min. O	ct.	23,1	945	Count	tryMaryland
Director		210 40 0.00	M Z F			<u> </u>								00.15-16-
_		Jsual Residence of Decedent  0a. State 10b. County	110	c. City, To	wn or Locatio	on							ì	0d. Inside City Limits
v any	- 1	-				Par	kvi	11e					1	1 Yes 2 X No
sho nce.	5	Maryland Balt:	Lmore			10f. Zip Co					10g. Ci	tizen of Wh	nat Countr	<b>y</b> ?
laryla 8a-f	Director	0e. Street and Number										TT	S. A	
he M	吉	3029 Parktown Re				2	123	4	010 1		No.			an Indian, Black,
vith t s 23a e not	ᇹ	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was	s Decedent on es, specify C	of Hisp uban.	anic Origir Mexican, F	n? (Specit Puerto Rica	y yes or an, etc.)	NO-		e, etc.	
ath v item	Funeral	1 Never Married 2 Marrie	Armed Forces?	No	1							0	T T1_ 4	• •
er de	표	3 Widowed 4 X Divorce	d If Yes, Give Year			Yes 2 X						Specify:		
rs aft ural' mine	<u>a</u>	15. Decedent's Education (Specify of		leted) 1	6a. Deceden	t's Usual Oc	cupatio	on (Give ki	ind of work use retired)	done	166	Kind of Bu	JSINESS/III	dusay
hour fra	율	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)												
36 in 72 han ficat	۱割	12				Print	er					Web 1		ing
with with her t	Completed	17. Father's Name (First, Middle, Las	st)				1	8.Mother's	s Name (Fi	rst, Midd	e, Maide	en Surname	<del>)</del>	
Figure 1	ြင္စု	Edward M. Dani							Neesh	ıa	Unkı			
12, d be lenta larke	Be	19a. Informant's Name/Relationship	(Type, Print )		19b. Mailin	g Address	(Street	and Num	ber or Rura	al Route	Number,	City or To	vn, State,	Zip Code)
shoul nd N is m	유	Edward C. Daniel			3029	Parkt	OWI	n Roa	id, Pa	irkv:	11e	, Mar	yland	1 21234
Malth a sum 27	1	20a. Method of Disposition	.5 (5011)	20b. Pl	ace of Dispos	sition (Name	of cen	netery,		ate	20	c. Location	- City or	Town, State
F. P.		1 X Burial 2 Cremation	Removal from Sta	le I	ematory or of		~	i	OF /2/	. /200	۱ ا ۲۸	Ralti	more	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show intury or other transmatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Spec		St.	Stani	slaus	Ce							
nit. I artm		21. Signature of Funeral Service Lic	ensee		22.	Name and A	ddress	of Facility	Schir	nune.	t Fu	neraı Mər	valn	a 21236
Dep Dep	·	-MU	U _		97	05 Be	Lai	r Koa	ad, Ba	alt.	HOLE	shock or h	eart	d 21236
ysicia		23a. Part I. Enter the disease, or co	mplications that caused	the death. I	Do not enter	the mode of	ayıng,	such as c	alulac or it	espirator	, arroot,	0110011, 0111		Between Onset ar Death
/Medica		failure. List only one cause on	a. Contact Gunsho	t Wound	d of Torso	and Mult	iple S	Sharp F	orce Inju	uries				Bodin
Examine	r	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	quence of)	):									
	i		b											+
	<u> </u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of	):									
	듵	cause. Enter Underlying Cause (Disease or injury that initiated  C.  Due to (or as a consequence of):												
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
760, icate be executed physician and			d											1
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787 rtific	an /ue		1 Live birth		2 ! ath 5 !	Fetal death			p3.	-/				
Box 687 e death certific the attending		1 Yes 2 No 9 Unkn	own g Unknown	timo o. do	5	Other (Spec	uy)				_			
of Vital Records, P.O. Box 687 ng Physician: The law requires that the death certific Physician: The law requires that the death certificate has been signed by the attending I	2 8	Part II. Other significant condition		th but not re	esulting in the	e underlying	cause	given in F	Part I.	23e.	Did toba	cco use co	ntribute to	o the cause of death?
P.O.			ns contributing to dear	ar bot not to	oosining	, ,				1	Yes	2 🗸 No	3 Pro	obably 4 Unknow
, P.C ires that	be det									24a.	Was an	24	b. Were a	autopsy findings avail
ords, w requir	age 2 should be										autopsy	- 1	prior to death?	completion of cause
SOI law	2 2 8									1 🗸	Yes 2		1 🗸	
Re The icate	, pag						26.Pla	ce of Deat	th (Check o	only one)				
of Vital Records, ing Physician: The law requir After this certificate has been s	ector, page	25. Was case referred to friedical	Hospital:	ient 2	ER/Outpati	ent 3	OA	Other <sub>4</sub>	Nursin	g Home	5 R	esidence	6 🗸 Oth	er: Scene
Lysic K	al dire	1 Yes 2 No	IIIpat		28b. Time			ijury at Wo	ork?	28d. De:	scribe ho	w injury oc	curred	1 -16
Of of Pl	funeral		28a. Date of In (Month, Day FOUND:	Year)	FOUND:	J. M.J ,		Yes 2		Subjec	t shot,	cut and	stabbe	d self
<b>-</b> =		1 Natural 5 Pendi	May 20, 200	7	0810 hrs					28f 1 oc	ation (St	reet and N	umber or !	Rural Route Number,
isi Att	rd I	2 Accident Inves	28e. Place of	Injury - At h	nome, farm, s	treet, factory	, office	e building,	etc.	or T	own, Sta	ete) e Road, F	Parkville	MD
Division tal or Attendii us after death.	filled in by the fune	4 Homicide deter	mined (Specify) S	ingle Fai	mily									
ospit hour			nysician: To the best of	my knowle	dge, death o	ccurred at th	e time,	, date and	place, and	due to th	ne cause	(s) and ma	nner as st	tated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely	(Check only one) 2 Medical Example 29b. Signature and title of certifie	miner:On the basis of ex	camination	and/or invest	tigation, in m	y opin	ion, death	occurred a	tne tim	e, uate a			
To T	com	29b. Signature and title of certifie	and mainter state	u		29	lc. Lice	ense numb	per			29d. Date	signed (I	Month, Day, Year)
_/	1	16					0.	C.M.E.				May 22	, 2007	
		Panuty wither	11,011		2000)									
A D		30. Name and eddress of person		f death (Ite	m 23a) aminer	111 Pen	n Str	eet. Balt	timore. I	MD 21	201			
L		Pamela E. Southall, M	an an											
	Sta	te 31. Date filed (Month, Day Year)	2007 32 Regis	trar's Signa	aure /	BACK !								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 18, 2007 12:15 PM Emma Mary Darnall /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2909 Craigston Lane Abingdon, MD Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 215-16-0389 7-23-1923 Director Maryland 83 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 le marked other than "naturel", or Iteme 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 Craigston Lane 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unknown Homemaker Own Home 7 le marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Stankie Emma Albrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 :
Department of Health ar
Important: If item 27 te
eny Injury or other trau Sheila Knight (Daughter) 2909 Craigston Lane Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland MemorialPark 5-24-2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Buin D. Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SMOUTH UNKNOWZY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 MONTH METASTASIS Ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been si Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an pege 2 has autopsy performed? certificate 1 ☐ Yes 2 X No Hospital or Attending Physicien: neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 🔀 No death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 31856 05/22/2007 S. ATWOOD RD #106 BRL AIR MD 2/2/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA 602 mp 32/Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 4 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 19, 1:30 ₽<sup>M</sup> MAY 2007 ROSEMARY DENISE KING DEBRO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GENESIS HEALTH CARE CENTER ANNE ARUNDEL BROOKLYN PARK 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖫 F JULY 16, MD Director 51 214-66-4201 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 DYYes 2 □ No Director MD ANNE ARUNDEL BROOKLYN PARK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a 613 HAMMONDS LA. USA death Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DATA ENTRY SPECIALIST MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 NORMAN KING ALICE SCRUGGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHARLE' DENITA STREETER/DAUGHTER 522 MATTHEWS AVE., BROOKLYN PARK, MD <u>21225</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/25/2007 BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CCI CREMATORY 22. Name and Address of Facility W. WESLEY CHAVIS, III FNRL. SERV. 21. Signature of Funeral Service Licensee 10684 SOUTHERN MD BLVD., DUNKIRK, MD 20754 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Muocardia disease or condition resulting in death) /Medical Due to (or s a consequence of): **Examiner** pertensi Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physiclan Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 💆 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28a Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: , filled in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD 21061 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Rond Minera 7845 DAGWOOD BUNNIE 31. Date filed (Month, Day, Year) State 4 2007 Registrar

		,	For State O  State O  Registrar	f Maryland / Depa <i>Cel</i>	artment of F <i>rtificate of</i>			ene 2007	16825
	Dhusisi	H	Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Charles F. Funk				Month 1	9-07	11:58 A M
>	Examin	er	4a. Facility Name (If not institution, give street and nur Manor Care, Ruxton	nber)	4b. City, Town, o	r Location of Death		4c. County of Death Baltimor	
-	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Ŀ	Director		216-20-0636 X X 2 F	80 Yrs.	Months Days	Hours Min.	Month, Day, Y Teb. 28,	1927 MD	intry)
	w w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho ied at	tor	MD Baltimore	Lutherv					1 □ Yes 2 <b>X</b> □ No
	r 28a	Director	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Cou	intry?
	23a c ust be	ralD	7 Elphin Ct. #202			1093		USA	
	er dea Items	Funeral	Armed Fo	edent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or Di	2 □ No //e ates: 45 ¹ -46 ¹	1 ☐ Yes 2 🛣 No	Specify:		Specify:	white
21215-0036	72 hou natura Ilcal E	ted	15. Decedent's Education (Specify only highest grade completed)	16a, Dece	dent's Usual Occup	ation during most of working	16	! 6b. Kind of Business/Ir	ndustry
2	ithin ne.	Completed	Elementary/Secondary (0-12) College (1	-4or 5+)	DO NOT use retired	d)	'	Transporta	
2	Hygier Hygier Ther th	CO	17. Father's Name ( <i>First, Middle, Last</i> )	Sales	/Business	Developme 18. Mother's Name		Engineerin	g
au	ld be i ental ked o	To Be	Godfrey Funk			Catherine		•	
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)		-	and Number or Rural	Route Number, C	City or Town, State, Zi	' '
χ. Σ	and 2 ealth m 27 I		Mary Jacqueline Funk/wif					e, MD 2109	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	State	matory or other plac	7/25/		c. Location - City or T	
Ħ	artmer ortant Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		oi the A 2. Name and A <u>dd</u> re	ssumption	Cem.	Baltimore,	MD
Ba	Depa Imp		Michael J Nagle		Lemmon Fu	neral Home	e of Dula Timonium	aney Valle , MD 21093	y, Inc.
5			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one c up e on e	aused the death. Do not ent ach line.	ter the mode of dyir	ng, such as cardiac or	respiratory arres		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in deeth)	uted Car	dion	copata	>		Onset and Death
	Examiner		Due to	(or as a consequence of):	1. Canh	ern			
		Jer	Sequentially list conditions, if any, leading to immediate	ui as a consequence of).	n seec.	~			
18	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		dise	else			
68760,	eath certificate be executed attending physician and for use as the burial-transit		Due to (	or as a consequence of):					
	ificate g phys	edical	d						
Box	th cert ending	an/M	23b. Was decedent pregnant	come pf pregnancy pirth 2 ☐ Fetal death 3 ☐	□Ectopic pregnancy	,		23d. Date of deliv	,
P.O. E	The law requires that the death certi te has been signed by the attending age 2 should be detached for use a	Physician/M		ant at time of death 5	Other (specify)			Month	Day Year
σ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to t	the cause of death?
Vital Records,	quires n sign	d by					1 □ Yes	2 No 3 Pro	bably 4  Unknown
000	aw rec	Completed					24a. Was an	24b. Were aut	opsy findings available
Ž	The lav	Com					autopsy performe 1  Yes 2	d? death? JNo 1 ☐ Yes	ompletion of cause of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Oth	26. Place of Death			
0	Phys r this ral dir	2	1 ☐ Yes 2 ☐ No 1 ☐ I	npatient 2 ER/Outpatier of Injury 28b. Time o		4 DE Nursing Hom	e 5 Residence  Bd. Describe how	ce 6 ☐Other (Speci	(fy)
on	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending (Mont 2 ☐ Accident investigation	th, Day Year) Injury	of 28c. Injur Wor M 1 □	k? Yes 2 □ No		injury occurred	
Division or	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of injury - At home, farm, str ng, etc. (Specify)	reet, factory, office	28	Bf. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	pital o		Continue Dhystelan To the	heat of my knowledge deat	de a consumed at the a 45	and data and data at	44		
	To the Hospital or Attending Physician: within 42 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; r	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the beautiful and maniful and	asis of examination and/or in her stated	ivestigation, in my o	ppinion, death occurre	d at the time, date	se(s) and manner as s and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	11 11	29c. Licens	e number	29d	. Date signed (Month,	Day, Year)
			1000	14 rece	OO H	007446	7 5	1-22-0	2/
	atl		30. Name and address of person who completed caus	e of death (Item 23a) (Type, cegistrar's Signature	Print)	1,#209	Timen	u, MO:	21093
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 4 2007	egistrar's Signature	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** PEARL GEORGETTA FARVER 22, 2007  $12:15 A^{M}$ MAY/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL HOSPICE - DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 89 9/5/1917 MARYLAND Director 213-16-9492 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No notified Director MD CARROLL FINKSBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or is 23a must 21048 1945 OLD WESTMINSTER PIKE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Ö 1 ☐ Yes 2 🔀 No Specify: WHITE þ 3 XWidowed 4 ☐ Divorced "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING ASSEMBLY LINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK DELBERT BARTHOLOW GEORGETTA DAVIS ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 7 19a, Informant's Name/Relationship (Type, Print) DONNA REESE -GRANDDAUGHTER 511 OLD MANCHESTER RD., WESTMINSTER, MD Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) EVERGREEN MEM.GARDENS 5/25/07 FINKSBURG, MD Signatur 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause a neach line. Immediate use (Final disease or condition resulting in death) mall Burrel Obs tructon Physician /Medical Due to (or as a consequence of) Examiner tib Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, 91 Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $_{4\square \text{ Nursing Home}}$  5  $\square$  Residence 6  $\Sigma$  Other (Specify) + OSPICE٩ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death to the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier r

State Registrar 31. Date filed (Month; Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2007 Ristrar's Signature

All Facility Name (if not institution, give street and number)   4a. Facility Name (if not institution, give street and number)   4a. Facility Name (if not institution, give street and number)   4a. Facility Name (if not institution, give street and number)   4b. City, Town, or Location of Death   Laurel   2b. City, Town or Location of Death   Laurel   2b. City, Town or Location   2b. Cit	Day Year 3. Time of Death 1007 3:08 M  4c. County of Death  Prince George  9. Birthplace (State or Foreign Country)
Physician Medical Examiner    Aa. Facility Name (if not institution, give street and number)   Laurel Regional Hospital   Laurel   Laurel Regional Hospital   Laurel   Laurel Regional Hospital   Laurel   Laurel   Laurel   Laurel   Laurel   Laurel   Laurel   S. Social Security Number   6. Sex   213-64-1402   Laurel   L	Day Year 1007 3:08 M 4c. County of Death  Prince George  ar) 9. Birthplace (State or Foreign Country) 958 Maryland  10d. Inside City Limits 1 🗷 Yes 2 🗆 No  Citizen of What Country?  S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
As a part of	4c. County of Death  Prince George  9. Birthplace (State or Foreign Country)  958 Maryland  10d. Inside City Limits  1 🛱 Yes 2 🗆 No  Citizen of What Country?  S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
Social Security Number   Social Security Num	9. Birthplace (State or Foreign Country) 958 Maryland  10d. Inside City Limits 1 🛱 Yes 2 🗆 No  Citizen of What Country?  S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
Director    213-64-1402   124M 2   F   48   Yrs.   Months   Days   Hours   Min.   Sept 7, 1	Country) 958 Maryland  10d. Inside City Limits 1 2 Yes 2 □ No Citizen of What Country?  S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
The part of the pa	1 ☑Yes 2□No Citizen of What Country?  S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
Juanita D. Elliott Frazier/wife 913 Park Avenue, #111, Laurel,  20a. Method of Disposition  1 Burial 2 MCremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Donaldson Funeral Home, P.A.  M00773 313 Talbott Ave. Laurel, Mar  23a. Part. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final)	Citizen of What Country?  S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
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Bunal 2 Decremation 3 Hemoval from State   4 Donation 5 Dother (Specify)   W. Arundel Crematory May 21, 07 Od   21. Signature of Funeral Service Licensee   22. Name and Address of Facility Donaldson Funeral Home, P.A.   M00773 313 Talbott Ave. Laurel, Mar   23a. Partl. Enter the Disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, more listed Cause (Final)   Immediate Cause (Final)   Imme	Maryland 20707
23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Location - City or Town, State
23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	enton, Maryland
Immediate Cause (Final	yland 20707-4389
Physician Immediate Cause (Final Contring Charles	Approximate Interval Between Onset and Death
resulting in death)	
Examiner Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Undershiping Cause (Disease or injury	
Due to (or as a consequence of):    Due to (or as a consequence of):	
cause (Disease or injury that initiated events resulting in death) Last  Co	
ficate be physicial in the bundance of the physicial in the bundance of the bu	
Due to (or as a consequence of):    Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last	23d. Date of delivery Month Day Year
L te for any ten of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc	o use contribute to the cause of death?
Yes to be deady to	2 No 3 X Probably 4 Unknown
	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?  1 Types 2 No.   Hospital: 1 Types 2 December 2 December 2 December 3 December 3 December 3 December 3 December 4 December	
1 Yes 2 No residence  1 Yes 2 No residence  1 No residence  1 No residence  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  28c. Injury at Work?	
28d. Describe how in 1 2 1 2 1 Manner of Death   28d. Date of Injury   28d. Time of Injury   28d. Injury at   28d. Describe how in   28d.	,,
25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 2 Residence 4 Nursing Home 5 Residence 2 Residence 4 Royal Place of Death (Check only one)  27. Manner of Death 1 Nursing Home 5 Residence 2 Residence 2 Residence 3 Residence 3 Residence 4 Royal Place 3 Residence 4 Royal Place 4 Royal Roya	and Number or Rural Route Number, ate)
The state of the s	(s) and manner as stated. and place, and due to the cause(s)
	Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SANTHI RANGANIA THAN 7300 VAN DUSEN RB, LAUREL MB 2	1 - 0 / 200-1
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 2 4 2007	•

			1 - State Registrar		epartment of Health and Certificate of Death	Reg. N	2001 10020
	Physic /Medi Exami	çal	Decedent's Name (First, Middle, Last)     Baby Boy Gibson      Aa. Facility Name (If not institution, give street)	t and number)	4b. City, Town, or Location of Dea	May 1.	3. Time of Death  OL. County of Death
	Funeral Director		The Johns Hocki 5. Social Security Number 6. Sex none	7. Age No yrs. last birth	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min 5		9. Birthplace (State or Foreign Country) 07 Maryland
	death with the Maryland ms 23a or 28a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  MD Worcester	10c. City, Town	lin		10d. Inside City Limits 1 ☐ Yes 2√ No
3	th with th	<b>Funeral Director</b>	10e. Street and Number 9100 Reedy Cove Driv	ve	10f. Zip Code 21811	10g. C	Citizen of What Country? USA
sque	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 X Never Married 2  Married 1	Vas Decedent Ever in U.S. Armed Forces? □Yes 2 ሺ No f Yes, Give /ear or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer      □ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black
	215-0 Ithin 72 ho le. Manical I	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	noleted)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
SB AKIA	Maryland 2121 nd 2 should be fied within alth and Mental Hygiens 27 is marked other than " r traumatic event, the Mar	To Be Con	none none none	e no	unk 18. Mother's Na	me (First, Middle, Maide cia Gibson	one on Surname)
8+	Mary d 2 shou th and M 7 Is mar traumat		19a. Informant's Name/Relationship (Type, P Johns Hopkins Hospi		Mailing Address (Street and Number or R		
Q	Baltimore, sernit. Pages 1 an Department of Heal mportant: If item 2 any injury or other 2008.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remov  '4 □ Donation 5 ☒ Other (Specify) ir	20b. Place of l	Disposition (Name of crematory or other place)	MATTER CANADA	Location - City or Town, State
	Baltir permit. P Departme Importan any injur		21. Signatur Guneral Service Licensee	Director	State Anatomy Boar Baltimore, MD 212		ltimore Street
•	Physician /Medical Examiner	Examiner	23a. Pant . Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ons that caused the death. Do not use on each line.  FITEME.  Due to (or as a consequence of	Prematurity	c or respiratory arrest,	Approximate Interval Between Onset and Death Minu tes
	Division of Vital Records, P.O. Box 68760,  To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	resulting in death) Last  d	Due to (or as a consequence of	):	-	
	15, P.O. BOX 68 res that the death certifica signed by the attending ph	Physician/Med	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	cords, F	þ	Part II. Other significant conditions contribut	ting to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
I	Division of Vital Records, I or Attanding Physician: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed				24a. Was an autopsy performed?	
	VIÇ	Be	25. Was case referred to medical examiner?	tal:	04	ath Check onl one	
	ion of inding Physeth. r: After this ie funeral di	ation: To	I Tes 20/No	1 Lympatient 2 ER/Outp 3a. Date of Injury 28b. Tir	Attent 3 DOA 4 Nursing P	dome 5 Residence 28d. Describe how inju	
i	Divisi To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:	Certification:	4 Homicide	le. Place of Injury - At home, farm building, etc. (Specify)		City or Town, Star	
	ha Hosp n 24 hou he Funei pletely fil	Medical	(Check only 2 Medical Examiner: C	n: To the best of my knowledge, On the basis of examination and/ and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	e, and due to the cause(surred at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  Possession (	a. Milia no	29c. License number	29d. D	ate signed (Month, Day, Year)
			30. Name and address of person who completed the state of	ted cause of death (Item 23a) (T		Notest Bel	fimure, MD 21284
	Sta Registr	_	31. Date filed (Month, Day, Year)  MAY 2, 4 2007	32. Registrar's Signature	and hotel 600 10 1	WELL DE DE	Illuare, 2 cis 84

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10 Q M Anthonie Gray 2001 /Medical 6 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner renera timore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1 X M 2 □ F unk 218-60-6344 Director June 16, 1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at MD ¹√Z Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Frankford Avenue 21206 USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No U
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify Specify: black 3 ☐ Widowed 4 ☐ Divorced 人のせんのりゃ (うため) Baltimore, Maryland 21215-003 "natural" Year or Dates Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un 16h Kind of Business/Industry un. (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk æ Pages 1 and 2 should be finent of Health and Mental Fant: If item 27 Is marked of ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland General Hospital 827 Linden Avenue Baltimore, MD20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5MOther (Specify) in state u of Funeral Service State Anatomy Board 655 W. Baltimore Street irector Baltimore, MĎ 21201 23a. Patt1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Que to (or as a consequence of Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner and burial-trai resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician requires that the death certificate be Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 Tes 2 No 3 Probably 4 nknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 s autopsy performed? Yes 2 2 No rJe 11itus this certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAY 24

2007

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year Month **Physician** Sally Steuart Goldsborough May 22, Рм 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6412 Pinehurst Rd Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 215-24-5744 Director DEC 1, 1925 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21212 6412 Pinehurst Rd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ites 1 Never Married 2 Married 1 □ Yes 2 No altimore, Maryland 21215-0036 Specify. Specify:White ģ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon B. Steuart Ida Randall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth G. Reese/Daughter 6412 Pinehurst Rd Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/23/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY **Physician** PISERSE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No ate has t autopsy performed? res 2. No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

DHMH 17 Rev 1/2001

State

Medical

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

**ORIGINAL** 

Ture

and manner stated.

12221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

more

29c. License number

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29d. Date signed (Month, Day, Year)

2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certains.  O.C.M.E.  O.C.M.E.  May 17, 2007  30. Name and address of person who completed cause if death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Attending Physer death.  rector: After thints of the funeral d	Fication: T	2 Accident		_	28e.	Place of In	ijury - At ni	31110, 101111,	Street, racti	ry, once			or	I OWII, 3			
290. Signature and title of certains.  O.C.M.E.  O.C.M.E.  May 17, 2007  30. Name and address of person who completed cause if death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year)  32. Registrar's Signature	ital or Attending Physurs after death.  ral Director: After thiseled in by the funeral d	artification. T	2 Accident 3 Suicide 4 Homicide	6 0	Could not determined	be 28e.	ecify)							F			nner as	stated
30. Name and address of person who completed caus of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner Theodore M. King, Jr., MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature	24 hours after death. 2 Funeral Director: After this Feliation of the funeral director of the filed in by the funeral direction of the funeral dir	Cortification		6 0	Could not determined	be 28e.	ecify)						-1	nd due to t	he caus	e(s) and ma	nner as ind due t	stated. the cause(s)
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baitimore, IVID 21201  State 31. Date filed (Month, Day, Year)  22. Registrar's Signature	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral d	Cortification	(Check only one) 2	6 Certifyin	Could not determined ag Physic Examined	be (Specian: To the	ecify) e best of masis of exa			ccurred at	the time, my opini	date and ion, death	place, a	nd due to t	he caus	se(s) and ma and place, a		
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  22. Registrar's Signature	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d	Cortification	(Check only one) 2	6 Certifyin	Could not determined ag Physic Examined	be (Specian: To the	ecify) e best of masis of exa			ccurred at	the time, my opini 29c. Lice	date and ion, death	place, a	nd due to t	he caus	se(s) and ma and place, a 29d. Date	signed	(Month, Day, Year)
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Registrar MAY 2: 4 2007		Cortification	(Check only one) 2 29b. Signature at 30. Name and ac	6 Certifyin Medical Ind title of ce	could not determined ag Physic Examined ertifier	be 28e. (Specian: To the band man	e best of m asis of exa ner stated.	my knowled amination a	ge, death o	ccurred at tigation, in	the time, my opini 29c. Lice O.6	date and ion, death ense numb	place, a occurre	nd due to t d at the tim	he caus	se(s) and ma and place, a 29d. Date May 17	signed	(Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:25 am Vernice G. Green May 07 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Agne HOSPITAL N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Maryland Dec 18, 1954 Director 213-62-9008 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Baltimore** N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21230 1116 Nanicoke Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or hand any Injury or other transmitted. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ZNo Baltimore, Maryland 21215-0036 Black Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **BWI Airport** Elementary/Secondary (0-12) College (1-4or 5+) Sky Chef 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Fleet William Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .116 Nanicoke Street, Baltimore, Md. 21230 Terrence Green 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Lansdowne, Maryland 05/25/07 Mt. Zion Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Caust (Final disease or condition backenial Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as early in the cause of Due to (or as a consequence of): burial-transi Exami that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Yea in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No perform Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Division or After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After the 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number *P 20 96 6* 

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Re Bulkinore, MD, 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bertha W. Gugliuzza /Medical 4a. Facility Name (If not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sep **Funeral** Year) 1 ☐ M 2 🕅 F Months Davs Hours Min. 93 28,1913 Maryland Director 214-03-3537 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show Examiner must be notified at 1 X Yes 2 □ No Directo N/ABaltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 "natural", or items 23a 20 Belhaven Drive 21236 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify þ 3 X Widowed 4 □ Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur. any injury or other traumatic event, the Medical E once. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Pawlowski Vincent Zagroba ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 101 Belhaven Terrace, Baltimore, Maryland 21236 Phyllis Gianotti (Dghtr) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/23/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes, ▶ 9705 Belair Road, Baltimore, Maryalnd 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause unleach line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1□ Yes 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t al or Attending F after death. I Director: After d in by the funera Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19/2007

State Registrar

30. Name and address of person who

DHMH 17 Rev 1/2001

ause of death (Item 23a) (Type, Print)

Registrar's Signature

ranklin

			1 - For Stata Registrar		laryland / Depa	artment of H			ene () ()	7 16834
	Physic /Medi		1. Decedent's Name (First, Middle, I	_				2. Date of Death Month	Day	Year  3. Time of Death  Year  4: 05 P M
	Exami		4a. Facility Name (If not institution, g	ive street and number	)	4b. City, Town, or	Location of Dea		4c. County of	
	Funeral Director		220-14-7696	Sex 7. A 1 □ M 2 □ F	ge (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year)	Birthplace (State or Pereign Country)  MD
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD NA		10c. City. Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the la or 28a Lbs motil	Director	10e. Street and Number			10f. Zip Code	0.05	10	g. Citizen of Wh	25
980	within 72 hours after death with the Maryland ene. then "netural; or Items 23a or 28a-f show its Madical Examinar mat by routified at	by Funerai	3704 Gwynn Oak  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Tes. Give Year or Dates:	Ever in U.S. 13. \		207 spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Ricen, etc.)		A - American Indian, . White, etc. Black
121215-0036	iges 1 and 2 should be filed within 72 hours atter death with the Marylar nt of Health and Mental Hygene. If item 27 is marked other then "netural", or items 23a or 28a-f show or other treumatic event. Ite Madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 5th grade 17. Father's Name (First, Middle, Las	rade completed) College (1-4or	5+) (Give life. L	lent's Usual Occupa kind of work done d OO NOT use retired)	wing most of wi Worker	orking		ate Homes
Maryland	should be f nd Mental h marked of umatic ever	To Be	Frank Brooks	,		_	Martha	me (First, Middle, Ma a Greenwe	ell	
Baltimore, Ma	Part and		19a. Informant's Name/Relationship  Lillian Green  20a. Method of Disposition  X Burial 2 □ Cremation 3    '4 □ Donation 5 □ Other (Spec	well-sis	law 3704	Gwynn sition (Name of aatory or other place	Oak At	Date 20	ltimore	e, MD 21207 ity or Town, State
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	nsee		Name and Address	s of Facility M	larch F/H		MD 21215
	Physician /Medical		3a. Pari . Enter the disease, or conshock, or heart failure. List only immed ate Cause (Final disease or condition resulting in death)	a. ASCU	110.	or the mode of dying	, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
8/60,	ificate be executed the physician and the burial-transit and the bur	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as	a consequence of):					years
O. Box 6	death certi e attending id for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3 1	Ectopic pregnancy Other (specify)		iii — s	23d. Date o Month	
ecords, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions		ut not resulting in the und		n in Part I.			ute to the cause of death?
<u>r</u>	The ate his	Completed	CERD					24a. Was an autopsy performed	d? prio	re autopsy findings available r to completion of cause of th? Yes 2□ No
	his d d	tion: To Be	25. Was case referred to medical examiner?  1	28a. Date of Injur (Month, Day	nt 2 ER/Outpatient  y Year)  28b. Time of Injury	3 □ DOA Other: 28c. Injury a Work?	4 Mursing H	ath (Check only one) dome 5 Residence 28d. Describe how	e 6 Other (	'Specify)
=	tal or Attending s after death. af Director: After ed in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined		rry - At home, farm, stree (Specify)		es 2 🗌 No	28f. Location (Stree City or Town, S	at and Number o	or Rural Route Number,
	he Hospi in 24 hou he Funer pletely fill	ledicai	one)	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death of examination and/or invested.	occurred at the time, stigation, in my opin	, date and place nion, death occu	, and due to the caus rred at the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
h	V Viit		29b. Signature and title of certifier	× mo		29c. License r		2	-/2010	fonth, Day, Year)
3	C	- 0	30. Name and address a person who wend luces	6. 0.	Charles &	tint) L Sint		2 700	None	md 21204
: 	Stat Registra	e ir	31. Date filed (Month, Day, Year)	07 32 egistra	r's Signature	W.				

DHMH 17 Rev 1/2001

07-03842 Marlon Gayle

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

anon Cayle		- For State Crivial yiard 7 Department of Fleath and Worldan Ty - For State Certificate of Death	Reg.	No. 201	77 1500
Physicia	an/	Decedent's Name (First, Middle,Last)	2. Date of Death	£ 0 1	3. Time of Death
Medical Exami		Marlon Nathaniel Gayle  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month D May 20, 200	7 4c. County of Dea	
,		7021 Plymouth Road Pikesville		Baltimore Co	unty
Funeral Director		5. Social Security Number 213-19-0913 6. Sex 1 Age (In yrs. last birthday) 35 Yrs. If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(I	,1972 Fore	irthplace (State or ignJamaica, ountry) WI
any	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
À	_1	Maryland N/A Baltimore			XX Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  ont: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once	Ë	10e. Street AVE 10f. Zip Code 2/208	10g.	Citizen of What Co	1
death with the Morrisens 23a or 2	Funeral	11. Marital Status 1 Never Married Never Married Never Married Never Married 12. Was Decedent Ever in U.S.  Armed Forces No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		White, etc.	erican Indian, Black,
s after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	ork dono	Specify: 3	lack
2 hour: "natu	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)			5/IIIddstry
036 ithin 7 rr than	Completed	12th grade Packer		Warehouse	
filed w Hygie d othe		17. Father's Name (First, Middle, Last)  18. Mother's Name	atte 1	rech	
21215-0036 vuld be filed within 7 Mental Hygiene. marked other than	To Be	19a. Informant's Name/Relationship (Type, Print.)  19b. Mailing Address (Street and Number or R	ural Route Numbe	er, City or Town, Sta	te, Zip Code)
e, MD and 2 sho Health and item 27 is		terol west juncte 19 HIEXANIA CA.	001193	11111	my
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours af ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural r other traumatic event, the Medical Examin		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,  Burial 2 Cremation 3 Removal from State	Date 2	Eleven Mile	Bull State
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other tr		4 Donation 5 Other Specify: Creening 6710	72007	Jamaica, WI	Ti al la
Baltin permit. J Departm Importa					Rel 2/215
Physician		23a. Pa . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of urre. List only one cause on each line.			Approximate Interval Between Onset and
/lviedical ⊂xaminer		Immediate Cause (Final disease a. Complications of diabetes mellitus			Death
) "		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  b.			
	Je.	frany, leading to immediate Due to (or as a consequence of):			
	Examine	Cilisease or injury that initiated events resulting in death) Last			
ecuted and transi		d. #730 PIL 77 por/VIE 0868 6/7/07 TI			
<b>60,</b> ate be ex hysician te burial .	Medical	Item#10e,perrH,0807,3/24/07,ws		224 Date of deliv	
876 tificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of deliv Month	Day Year
Box 687 e death certific the attending 1 ed for use as t	Physician/	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown			
D. Bo t the de by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the stand feath.  The The reach of the this certificate has been signed by led in by the funeral director, page 2 should be detach	d by	Congestive heart failure	1 Yes	2 No 3 P	robably 4 Unknown
ords v requi	Completed		24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
Recc The lav	Juno:		perform 1 <b>Y</b> Yes 2		
tal F tian: certific ector, 1	Be C	25. Was case referred to medical examiner? 26.Place of Death (Check Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, Nursin			
f Vi Physi er this	욘	1 V Yes 2 No	g Home 5 R	esidence 6 V Ot	ner: Scene
on Conding ath.	tion	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
ivisior for Attend after death. Director:	ifica	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
Di spital nours a neral I	Certification:	4 Homicide determined (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause at the time, date ar	s) and manner as s nd place, and due to	tated. the cause(s)
To To Com	Med	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (i	
N. J.		Qual 2 O.C.M.E.		May 21, 2007	
Sobor		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	trar	MAY 2 4 2007 Aleges 18			<del>_</del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Betty Greer Glenn 18. 2007 9:47 A /Medical May 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center @ GBMC Baltimore Towson 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 1 F Yrs. Director 213-28-6647 Feb. 24, 1930 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Glen Gate Court 21014 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 22 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude H. Greer 2 Iva Jane Howell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau William E. Glenn Jr./Husband 20 Glen Gate Court, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/22/2007 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Signalure of Funeral Service Uncensee 22. Name and Address of Facility McComas Funeral Home, P.A. Lamas to My 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart bidure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1VYV MUCES month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence State (Specify) No Spuid 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1X Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 2 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001 29d. Date signed (Month, Day, Year)

			1- State of Maryland / Department of Health Continuate of Death	and Mental H	ygiene Reg. No.		16837
			Decedent's Name (First, Middle, Last)     Ann	2. Date of I	Death	/ Year	3. Time of Death
	Physic /Medi		Anna Carmel Guernsey	May	21	200	7 8:30A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	of Death		County of Dea	
			Hopkins Eldercare Plus Sparrows Poi  5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under			altimore	
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Age (In yrs. last birthday) 1 Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 2 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 1 If Under 1 Year 2 If Under 1 Year 2 If Under 1 Year 3 If Under 1 Ye	Min. 8. Date of E	Birth Day, Year) 4/192	9. Bir Ci Ma	thplace (State or Foreign buntry) ryland
			Usual Residence of Decedent	1 00/2	4/132	U Ma	rylanu
	nylan how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Ma	Director	MD N/A Baltimore				1 Ves 2 No
	vith th	Dire	10e. Street and Number 10f. Zip Code		1,00	izen of What Co	ountry?
	s 238		5209 Barbara Avenue 21206	sising (Consit. Vo. salt	U.S.		nion Indian
	ter de	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 X Never Married 2 Married  1 Yes, specify Cuban, Mexica	rigin? (Specify res or r an, Puerto Rican, etc.)	NO-	14. Race - Ame Black, Whi	
Š	urs af	by	If Yes, Give 1 ☐ Yes 2 No Specify.  3 ☐ Widowed 4 ☐ Divorced Year or Dates:	<i>r</i> :		Specify: W	hite
2	72 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	et of working	16b. Ki	ind of Business	
ž	Man "	nple	Elementary/Secondary (0-12) College (1-4or 5+)	st of working			
2	ygier rt, th		Sales Person			tail Sa	les
	and I be fi Intal H ed ou	Be		ner's Name (First, Midd	lle, Maiden	Sumame)	
1	iryii thould the Me mark matic	2	Elmer J. Guernsev  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb	a Darago Der or Bural Boute Num	ther City o	r Town State	Zin Code)
2	<b>BAITIMOFE, IMARYIANG ZIZIO-U030</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any highly or other traumatic avant. The Medical Examinat must be multilled at any page.		Veronica I. Reiss, Cousin 5209 Barbara Aver				11.000
9	s 1 ar		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Lo	ocation - City or	Town, State
	Page Page nent of nt: #		Tabunal 2 Cremation 3 Pernoval from State	05/25/2007	7 Ralt	rimore	Maryland
3	Dalt permit. Departn Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facil	lity Leonard			
	<b>n</b> 89		Metandia Bates 5305 Harford Ro				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.		arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)  a. ALZHELMEY'S DISEA	اهـ			Onset and Death
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í	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of de Month	livery Day Year
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7	COTOS, P.O.  w requires that the been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e. Di	d tobacco u	use contribute t	o the cause of death?
, a ' +	VICAL RECONDS, sician: The law requires t certificate has been signe irector, page 2 should be or	Completed by	HTN, anxiety		]Yes 2	<b>⊘</b> No 3□P	robabły 4 🗆 Unknown
2	ecor law req as beer 2 shou	lete	J	24a. W	as an	24b. Were a	utopsy findings available
ern	The lar	шо		au pe	topsy rformed?	prior to death?	completion of cause of
ي ره	VIÇAI KÇ iician: The lav certificate has rector, page 2	0	25. Was case referred to medical 26. Plac	1 ☐ Yes se of Death (Check onl	$-\sim$	1 ☐ Ye	7 <b>0</b> NO
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	on or ling Phys After this funeral di		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury Work?	28d. Describ	e how injur	ry occurred	Living
_	Attanding r death. actor: After by the fune	cati	2 Accident investigation M 1 Yes 2		(0)		Fachity
2	DIVISION  I or Attanding  I after death.  I Diractor: After  d in by the fune	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or 1	Town, State	e)	ural Route Number,
4.	DIVISION  To the Hospital or Attance within 24 hours after death To the Lunaral Director: completely filled in by the		29a. Certifier 1 2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date at	and place, and due to the	ne cause(s)	and manner a	s stated.
	1 24 h	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, decone)	eath occurred at the tim	e, date and	d place, and du	e to the cause(s)
	To the within 2 To tha complet	M	29b. Signature and title of certifier 29c. License number			te signed (Mon	
	*X		M. Ushebey 045	757	M	cy ?	21,2007
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D	1.1		21,2007 W 21224
			Matter McNalncy 4940 Easte  31. Date filed (Month, Day, Year)  32. Registrar's Conature	rn DC	-17-21	-86° (	NO CLECY
	St Regist	ate rar	Matthew McNalncy 4949 Easte  31. Date filed (Month, Day, Year)  AY 2 4 2007				

			1 - For State Registrar		State	of Mar	yland / D				ealth a Death	and Me		giene Rog. No.	2 U.	17	168	38
			Decedent's Name (First, Mid	dle, Las	st)								2. Date of De	ath			3. Time of De	ath
	Physici		Harold S. Ha:	ris	3								Month May 14	. Day	) 07	'ear	6:44 A	мм
	/Medio Examin		4a. Facility Name (If not institut	on, give	street and n	umber)			4b. City,	Town, or	Location of				County of	Death	, , , , , , ,	
			105 Avondale	Cir	cle				Sev	verna	a Par	k		Ar	ne Ai	cund	le1	
	Funeral		5. Social Security Number	6. S		7. Age (	'In yrs. last birt		If Under Months	1 Year Days	If Under	24 Hrs. 8	8. Date of Bird (Month, Da	h v. Year)	9	. Birthp	olace (State or Forty) York	oreign
	Director		062-12-2839	'	<b>∑</b> M 2□F		86	Yrs.		Dayo		A	Aug 8,	192	0	New	York	
	pue M		Usual Residence of Decedent  10a, State  10b, Coun	hv		1	Oc. City, Town	or Loc	ation							1	I0d. Inside City I	Limite
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	with se or	Funeral Director	105 Avondale	C i w	.1.				701. 2.10					rog. om	2011 01 1111	at oou	, .	
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<u> </u>	should be filed within 72 hours after death with the Maryland of Mental Hygene. Tharked other than "natural", or iteme 23a or 28a-f ehow marked other than "natural", or iteme 23a or 28a-f ehow marked other than "natural".	Be	17. Father's Name (First, Middle LeRoy Joseph										First, Middle,		Sumame)			
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Danilli	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-f show any Injury or other traumatic event, Ita Medical Examinat must be institled at ODGs.		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other			n State	20b. Place of cemeter	y, crema	atory or o	ther place	9)			200. 20	ocation · Oi	ty 0, 10	Jani, Otate	
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2	s afte	Certification	4   Homicide		Ouli	ding, etc.	(Бреспу)						City or Tov	vn, State	)			
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours atterdeath. Within 24 hours atterdeath. To the Furnetiel Director: Affer this certificete hes been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	edicai (	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Ph	niner: On the	ne best of a basis of ea anner state	my knowled je xamination and d.	death o	occurred estigation	at the tim , in my op	e. date and inion, deat	d place, an th occurred	d due to the	cause(s) date and	and mann I place, and	er as si	tatad the cause(s)	
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			30. Name and address of person	1 1	completed car		th (Item 23a) (	Туре, Р		he	1/2	141	h 1 12	A	rnol	1	Mo 2	101
	Sta	_	31. Date filed (Month, Day, Yea	r)	32/		s Signature	Son a	وعظه		VI -	NAIT	1-3		1 14		,	1 4
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		_	For State Registrar	State of Maryland	-	artment			and M	R	eg. No.	15839
Phy	ysicia		Decedent's Name (First, Middle, Last)							2. Date of Deat Month	Day Year	3. Time of Death
, /N	Nedic	al	Louis Jacob Hutz				-	1	10	May 2	22, 2007	7:45 P M
Ex	amin	er	4a. Fecility Name (If not institution, give s Ellicott City Heal		ation	1		Location o			4c. County of Death	1
Fun	oral		5. Social Security Number 6. Sex			If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,		nplace (State or Foreign
Direc				[M 2□F 90	Yrs.	Months	Days	Hours	Min.	$\mathop{ m July}^{{\scriptscriptstyle (Month,\ Day,}} 14$ .	1916 Mar	y <b>1</b> and
ъ.			Usual Residence of Decedent	10c. City, T								
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death	200	Funerai		12. Was Decedent Ever in U.S.	13.			spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	JSA 14. Race - Amer	ican Indian,
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Ind 21215-0036  be filed within 72 hours after des ital Hygiene. Ind other than "natural", or itema	ent,	0	17. Father's Name (First, Middle, Last)	į, D.	ar cac	Lar	101				Maiden Surname)	ı Ly
Maryland 21215-0036 nd 2 should be filed within 72 hours aff tith and Mental Hygiene. 27 is marked other than "natural", or	tic ev	To B	Jacob L. Hutzler					Minn	ie U	Unk.		
2 sho	other traumatic		19a. Informant's Name/Relationship (Type	pe, Print)	9b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	l Route Number	City or Town, State, Z	ip Code)
and and maz7	her tr		Gary Hutzler/Son	2001-1714	L348	Hollo	w Gl	en C			Bay, MD 21	
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item	or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	etery, crei	sition (Nam natory or ot	her place			1.0	20c. Location - City or	
Iting Iting	njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			Memo: Name and				/25/07_	Marriottsv	ille, MO
Baltimore permit. Pages ' Department of H important: if ite	any		21. Signature of America Solvice Education	Todd Dring	Ma	cNabb	Fur	eral	Home	e, P.A.	e, MD 2122	0
		1	23a. Part1. Enter the disease, or compli	cations that caused the death.	o not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	e, MD 2122	Approximate
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2 a 00		= +				-						
Box 61 leath certific attending p	esn	Physician/Med	230. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pre	agnangy				23d. Date of deli	very
O. B. death	ed for	sicia	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4 Pregnant at time of death		Other (spe					Month	Day Year
P.O. nat the de d by the	etach	Phy	9 Unknown							no Distri		#
	pe q	ğ	Part II. Other significant conditions con	tributing to death but not resultin	g in the u	nderlying ca	ause give	n in Part I.			pacco use contribute to os 2□No 3□Pro	
Records, he law requires to a has been signed.	hould	eted										
ے و ۳	N	ompleted								24a. Was a autops perforr	y prior to c	topsy findings available ompletion of cause of
_ <del>_</del> <del>_</del> <del>_</del> <del>_</del> <del>_</del> <del>_</del> <del>_</del> <del>_</del> <del>_</del> <del>_</del>	ο.	မ င်	25. Was case referred to medical						15	1 ☐ Yes	No 1 ☐ Yes	212 No
	- E	OB	examiner?	ospital: 1  Inpatient 2 ER	Outpatier	nt 3 DO	A Othe	r . /		(Check only on ne 5 ☐ Beside	e) ince 6 Other (Spec	ufv)
	77	L	27. Manper of Death		b. Time o		Bc. Injury Work				w injury occurred	<i>(1)</i>
VISION Attending r death.	ne funer	atio	Natural 5 Pending 2 Accident investigation	(Month, Day 16al)	Injury	М		: ′es 2□	No			
Division i or Attending after death. Director: Afte	by t	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory	, office		2	28f. Location (St City or Town	reet and Number or Ru , State)	ral Route Number,
Oltei o urs afi	lled ir											
Div To the Hospitei or vithin 24 hours after To the Funeral Dire	itely fi	edicai	29a. Certifier  (Check only 2 Medical Examir one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, deatl and/or in	n occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the ca ed at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
To the within 2 To the	omple	Med	29b. Signature and title of certifier	And marmer stated.		29c	. License	number		2	9d. Date signed (Month	, Day, Year)
∺ <b>₹</b> ⊣	0		Jasuen	Kalllam			7 8	2859	2		5/23/07	-
- 1	1	-	30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type,	Print)	0	0			BALD MD	. 0
2+	1		TO - I FTOO / ALL	AN1, 2835	Smi	TH /	NE,	Sui	ITE ?	L03, 1.	DAUD MID	21207
	Sta		31. Date filed (Month, Day, Year)	Registrar's Signature	has	de						
Re	gistra	ar -	MAY 2 4 2007	MANUAL NO.	7							

			For State Registrar		State	of Mar		l / Dep		t of H	ealth a	and Me		eg. No.	007	15840
ı	Physici /Medio		1. Decedent's Name (First, Midderny N	(e, Last)	vin		HI	LL	<u>_</u>				2. Date of Dear	18	07	3. Time of Death  12:30PM
*	Examin	200	4a. Facility Name (If not institution Baltimere Rehabi	n, give s	treet and no	mber)	tena	leet;	4b. City,	Town, or	Location o		ne air	4c. Co	inty of Death	A
*	Funeral Director		5. Social Security Number 217-22-8553		M 2□F	-		st birthday Yrs.	-	1 Year Days	If Under a		8. Date of Birth		9. Birth	place (State or Foreign Maryland
	s Maryland s-f show	ctor	Usual Residence of Decedent  10a. State  Maryland  10b. Count	N/A	4	1	Oc. City,	Town or L	ocation	Ва	ltimore					10d. Inside City Limits 1 Yes 2 □ No
	3a or 28	I Director	10e. Street and Number 2601 Gwynndale Av	enue					10f. Zij	Code	2120	)7	1	0g. Citizen	of What Cou	Ctrys
980	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23a or 28s-f ehow event, the Madical Expriner most be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	ried	2. Was Dec Arged F 1 X Yes If Yes, G Year or	orces? 2 ∏ No ive	400	3	If Yes, spe	dent of Hi city Cuba 2 No	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White, ecify:	
Maryland 21215-0036	I within 72 he iene. Iene. r than "natu	ompieted	15. Decede (Specify only high Elementary/Secondary (0-12)		completed	) (1-4or 5+)		16a. Dece (Give life.	edent's Usu s kind of wo DO NOT u	al Occupa ork done d se setired Shoe	tion furing most Repair	of working	9	16b. Kind o	Self Em	
/land	buld be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle	larry .	J. Hill						18. Mothe	r's Name (	(First, Middle	Maidar Ann	pame)	
Man	12 should hand 7 iem	•	19a. Informant's Name/Relation Goldie Morsell Siste	ship <i>(Ty)</i> F	oe, Print)			19b. Maul 3	ing Address 410 Pie	dmont	Avenue	Baltim	Route, Maryl	and 212	16 <sup>State, Zij</sup>	Code)
Baltimore,	es 1 a of Hea if item or othe	100	20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (		emoval from	State	20b. Pla Gar	nce of Disp metery, cre rison F	osition (Na matory or o prest Ve	ne of other place terans	"Cemet	ery 0	5/29/07	20c. Locati	on - City or T Owings M	own, State ills, Md.
Balt	permit Pag Depertment important: any injury o		21. Signature of Funeral Springs 23a. Part1. Enter the disease, chock, or heart failure. Lis	1	8	b	W.S	1	13	300 Eu	taw Pla	ice Balt	Service, f imore, Md	21217		
760,	Physician /Medical /Medical Examiner partial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to	(or as a control of or a control of or a control of or as a control of or	conseque	ence of).	An	dic ter	) my	184	ithy euse			Onset and Death
.O. Box 68	death certifica e ettending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2		birth 2 nant at tir	Fetal	death 3	□Ectopic p					23d.	Date of deliv Month	Pery Day Year
۵_	sign Sign d be	by	Part tl. Other significant condit	ons con	tnbuting to	death but	not resul	ting in the	underlying	ause give	en in Part I.			bacco use		the cause of death?
al Records,		Completed											24a. Was a autops perform	sy .	4b. Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of
Vita	Physicien: This certifical director, p	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No		lospitat:	Inpatient	2 □ E	R/Outpatie	ent 3 D	Othe	25		(Check only or		Other (Speci	WHENICO
sion of	Te le	ation: T	27. Manner of Death  1 Natural 5 Pend 2 Accident inves	igation	28a. Date	of Injury oth, Day	- 2	28b. Time Injury		28c. Injury Work	at	28	8d. Describe h			··· (IO Spires
Division	s after de s Direct	Certification:	3 Suicide 6 Could 4 Homicide deter	not be	28e. Plac buil	e of Injunding, etc.	y - At hon (Specify)	ne, farm, s	treet, factor	y, office		28	8f. Location (S City or Tow		umber or Aur	al Route Number,
	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (	(Check only P   Medica	t Examir	ler: On the	hasis of a	vaminati	on and/or i	nyastigation	in my or	ninion dear	th occurre	nd due to the c d at the time, d	ate and nia	co and due !	o the cauca(c)
	To the vithin 2 To the complet	Me	29b. Signature and title of writing	1	P				29	c. License	number 41	210		9d. Date si	gned (Month,	Day, Year)
5	- 1		30. Name and address of perso	who co	mpleted car	use of dea	ath (Item	23a) (Type	Print)		RI	0	R 11		10/0	21218
	Sta Regist		31. Date filed (Month, Day, Yea MAY 2	4 20	07 32	legistrar	's Signati	" A	ocyr	avet s	7 011	1	Pallin	nore	. ניטע	Day, Year)  7  21218

			For State Registrar	State of Ma		Department of Certificate of	Health and N	lental Hy	giene Reg. Ne2	0 7	16841
	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last CLO Hin  4a. Facility Name (If not institution, give	ton street and number)	<i>(</i> 1 1	4b. City, Town,	or Location of Death	2. Date of De. Month May	18	ZÓÖ'7	3. Time of Death 9;30 P M
	Funeral Director				ttended  o (In yrs. last bir  89	CREE	If Under 24 Hrs.	8. Date of Bird			place (State or Foreign Marolina
	e Maryland a-f show	ctor	Usual Residence of Decedent  10a, State 10b, County N/	/A	10c. City, Tow	n or Location E	Saltimore				10d. Ingde City Limits 1 XYes 2 ☐ No
	h with th	al Dire	10e. Street and Number 301 McMechen Street			10f. Zip Code	21217		10g. Citizen o	f What Cou	ftry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28s-f show any Injury or other traumatic event, tra Medical Examinar must be rotified at ance.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Anged Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	4044	13. Was Decedent of If Yes, specify Cut		ecify Yes or No Rican, etc.)	- 14. Ra BI Spec	ace - Americack, White,	can Indian, etc. Black
21215-0036	in 72 ho n "natu	pletec	15. Decedent's Edu (Specify only highest grad	e completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of	Business/In Bethlehei	
212	ygiene. ygiene. r, Ire	Com	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Crair					
land	uld be fill fental H rked ott	To Be	17. Father's Name (First, Middle, Last) John 1	-linton			18. Mother's Nam	e (First, Middle	ara <sup>id</sup> Procti	ope)	
, Maryland	and 2 should ealth and Men n 27 is marke tar traumatic		19a. Informant's Name/Relationship (Ty Delores Ford	rpe, Print)	19b	Mailing Address (Street 14 Cree Coun	t and Number or Rur Randalistown	al Route Numb , Maryland	21133 <sup>Tow</sup>	n, State, Zip	Code)
Baltimore,	t. Pages 1 attment of He rtant: If item njury or othe		20a. Method of Disposition  1	1-1-1	20b. Place of cempter Garriso	Disposition (Name of y, crematory or other plan n Forest Veteran	s Cemetery	Date 05/25/07		n - City or To wings M	
Bal	permit. Depertr Importa		21 Signature of Funeral Service Licens	** 25 Ce	X SA	22. Name estép 1 1300 E	Stothers Funer utaw Place Ba	ral Service, altimore, Mo	P. A. 21217		
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to mmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	Stage a consequence	Cardion	ng, such as cardiac ny opath	or respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	ficate be executed physicien end s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):					
.O. Box	The law requires that the death certificate E lie has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у			ate of deliver	ery Day Year
ds, P	ires that the signed by detac	þ	Part II. Other significant conditions con	ntnbuting to death b	ut not resulting in	the underlying cause gr	ven in Part I.		obacco use co	ntribute to the	ne cause of death?
of Vital Records,	has been sige 2 should	Completed						24a. Was	an 24b	. Were auto	ppsy findings available
talF	ysicien: The l is certificate ha director, page	0	25. Was case referred to medical				26. Place of Deat		rmed2 2 No	death?	21 No
<u>=</u>	Physicien: this certifica ral director, p	ToB	examiner?	lospital: 1 Inpatie	int 2□ER/Ou	tpatient 3 DOA	ner: 4 Nursing Ho		-7	ther (Specif	'y)
Division o	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		ime of 28c. Injury Wo	ry at rk? ]Yes 2 □ No	28d. Describe h	now injury occu	urred	
Ž	tel or Attencs after death	Certific	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, fa c. (Specify)	rm, street, factory, office		28f. Location (5 City or Tox		nber or Rura	al Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the funer	Medical (	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the best ner: On the basis of and manner sta	examination and	, death occurred at the ti d/or investigation, in my	me, date and place, opinion, death occur	and due to the cred at the time,	cause(s) and n date and place	nanner as s o, and due to	tated. the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	Wil	w to	ΠD. 29c. Licen	11365	t	29d. Date sign	8,2	007
	0			1 4		Type, Print) 3900 Loc	h Raven	Boulev	rard, Bo	attim	ore, MD 21218
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	Coexter.					

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month Physician Luia Hunt 9:45 100 22 01 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balhonere aemesis Hamilton H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 M 2 F 217-26-8097 74 Yrs. Director NORTH Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mast be notified at 1 1 Yes 2 No mD Director BALTO. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? HESTER 21213 1804 N. USA Funerai 14. Race - American Indian, Black, White, etc. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: BLACK à If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cook COLONIAZ - O-17. Father's Neme (First, Middle, Last). 18. Mother's Name (First, Middle, Maiden Surname) Be MC INTOSH HARLES KHINEHART EFFIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cousin ST. 902 HARRIS MCILLE KOSEDALE BALTO. mD. 21216 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Injury or MARYLAND NATIONAL 5-30-07 LAUREL MARYUM 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIES FUNDE AL HOME 21. Signature of Funeral Service License N. MONROE ST. 1721-27 BALTO MD 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical a ASCUD hears Examiner Due to (or es a consequence of): Examiner 17 TH Hospital or Attending Physician: The lew requiras that tha death certificate ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Vinheres Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2/Q No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2 No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct à 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. completaly (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number Kluy DJ1295 5/24/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\mathcal{Q}_{\prime}$ Wends N Charles St Suite 4202 K10432

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

MAY 2 4 2007

ORIGINAL

32. Registrer's Signature

			For State Ragistrar	State o	f Marylan	-	artment rtificate			and M		gienez Reg. No.	007	16843
	B)		1. Decedent's Name (First, Middle, Las	it)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Donald Melvin Le	wis Hag	gan						May	21,	2007	4:00 A M
	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		4c. C	ounty of Oeat	h
			Harford Memorial						de G				Tarford	
	Funeral		5. Social Security Number 6. So	ex DXM 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)		nplace (State or Foreign untry)
	Director		217-74-6285 Usual Residence of Decedent		74	113.	Ll.				Jan. 6	, <u>193</u> 3	3 Mai	cyland
	Maryland -f ehow lled at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	the Marylan r 28a-f ehow notified at	ţō	Maryland Harf	ord		Bel	\ir							1 ☐ Yes 2√∑ No
	death with the me 23s or 28s revest be not	Director	10e. Street and Number	.020			10f. Zip	Code				10g. Citize	n of What Co	untry?
	15 wit	alD	408 Schucks Rd.					2101	5			τ	JSA	
		Funeral I	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spo	ecify Yes or No Rican, etc.)	- 14	Race - Ame Black, White	
9	or it	J.F.	Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 No	l	1 ☐ Yes 2		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , ,	1	pecify:	o, 6to.
چير ا	ural'	d by	3 Widowed 4 Divorced	Year or D	ates:								V	√hite
7	within 72 hours after ene. then "natural", or Ite	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	uring mos	t of work	ng	166. Kind	of Business/	industry
7 2	filed with Hygiene. other ther	E O	Elementary/Secondary (0-12)	College (1	-4or 5+)		sable		,					
<u>ğ</u>	be filed withital Hygiene. d other therevent, the M	BeC	17. Father's Name (First, Middle, Last)				Javic		18. Mothe	r's Name	(First, Middle	, Maiden Si	umame)	
<u></u>		ToB	Chester Farl Hac	ıan					Lul	a Ma	e Prest	on		
Maryland 21	2 should be filed witt and Mental Hygiene is marked other the eumatic event, ma		19a. Informant's Name/Relationship (7	Type, Print)		19b. Maili	ng Address	(Street a			I Route Numb		Town, State, 2	(ip Code)
$\gamma$	5 4 5 E		Hazel Billings /	Sister		_	The state of the s		Rd.,		Air, N	Maryla	and 210	)15
Z 10	of H		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Removal from	1 /	Place of Dispo cemetery, crea	sition (Nam matory or of	ne of ther place	θ)		Date	20c. Loca	ition - City or	Town, State
, ' \ E	permit. Pages 1 au Department of Hea Important: If Item eny injury or othe once.		4 ☐ Donation 5 ☐ Other (Specify	1)		l Air I	Memori	ial		5-2	5-07	Bel A	ir, M	aryland
	permit Depar Impor eny in		21. Signature of Funeral/Service Licen		1	2:	Name and McComa	Addres	s of Facilit	) Ho	me, P.A	٨.		
	40200			mye f	<u></u>		_50_W.	. Bro	oadwa	$\mathbf{v}_{\bullet}$ $\mathbf{E}$	el Air,	, Mary	land 2	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	one cause on e	ach line.	1							,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. COV	nmu	inin	26	TPL	cine	1	meu.	mol	110	
	Examiner			Due to	or as a conseq	juence of): C	j							
		e	Eaguentian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated each	Due to	or as a conseq	uence of):		_						
	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events	с.										
o.	e exe ian ar urial-t	Ex	resulting in death) Last		or as a conseq	uence of):								
8760.	@ <u> </u>	lical		. d										
ω ×	n certifica Inding pt use as t	Med	IF FEMALE:	00- 11										
Вох	eath certif attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna inth 2  Feta	I death 3	Ectopic pre					23	<li>d. Date of deli Month</li>	ivery Day Year
0.0	at the de by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn	ant at time of down	leath 5	Other (spe	эспу)						,
	that ned by deta	y Ph	Part II. Other significant conditions of	ontributing to d	eath but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
A Records.	quires n sign ald be	d by	Sleep 20	nea	. N	ror	610C	7			1 🗆	Yes 2□	No 3∏Pr	obably 4 Unknown
Ö	w requ	jete	per ch		/						24a. Was	an	24b. Were au	topsy findings available
	The law	Completed									auto perfo	psy prmed2	prior to death?	completion of cause of
)6ηα  of Vital	iclan: T certificat rector, p	0	25. Was case referred to medical			-			26 Place	of Death	1 Yes	- 4	1 LI Yes	2 No
6ηα of Vita	Physiclan: r this certifica ral director, p	To B	examiner? 1 □ Yes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3 00	A Othe	25		me 5□Resi		☐Other (Spe	cifv)
		Ë.	27. Manner of Ceath 1 ☑ Natural 5 ☑ Pending	28a. Date	of Injury	28b. Time o	f 2	Bc. Injury Work			28d. Describe			.,,
2 0	Attending r death. octor: After by the fune	atic	2 ☐ Accident investigation	1			М		Yes 2	No				
an, L Division	or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At he ng, etc. (Specif	ome, farm, st (y)	reet, factory	, office			28f. Location ( City or To		Number or Ru	iral Route Number,
Jagan	Hospital 24 hours a Funeral C	S	29a. Certifier 1 Cartifying Ph	valaian. To the	hank of many from									
70	24 hc 24 hc Fun etely	edicai	29a. Certifier 1 Cartifying Ph (Check only one)	imer: On the b	asis of examina ner stated.	tion and/or in	n occurred a vestigation,	in my of	ie, date an pinion, dea	d place, th occurr	and due to the ed at the time,	date and p	nd manner as lace, and due	to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	₩ We	29b. Signature and title of certifier			T. a k	29c	. License	number		2/12	29d. Date	signed (Mont	h, Day, Year)
	1		<b>→</b> (1) (1) 1	1		MI	7 (	0 (	06	30	142	5/	211	07
-	2		30. Name address of person who	completed case	death (Iter	n 23a) (Type,	Print	01				-1	b	0
0	L'.		tring M	iludy	Ing les	40	201	04	Me	4 CC	esupe	ehe	der	- Beltt
	Sta Registi		31. Date filed (Month, Day, Year)	7 49.4	egistrar's Signa	ature par	w				V			

			For State Registrar	State of Maryland / D	epartment of Certificate			ene2 0 0 7	16844
	Physici		1. Decedent's Name (First, Middle, Last)	HAYES			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give s HARSOR HOS	rtreet and number)	4b. City, Tov	vn, or Location of Death	1.417	4c. County of Death	
I	Funeral Director		5. Social Security Number 6. Sex 212-46-8004		hday) If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Aug. 15		place (State or Foreign ntry) ryland
backack o	lified at	ctor	10a. State 10b. County  Maryland Baltimor	10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 No
đị Đị	3a or 2	i Dire	10e. Street and Number 200 First Avenue		10f. Zip Co 212			g. Citizen of What Cou	ntry?
5-0036	al, or tams 2 Examiner mus	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₾ No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify 1  Yes 2	of Hispanic Origin? (Spe Cuban, Mexican, Puerto No Specify:		14. Race - Ameri Black, White,	
Maryland 21215-0036	iene. rthen "natur ine Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th Grade	completed) Coilege (1-4or 5+)	Decedent's Usual O (Give kind of work d life. DO NOT use n	one during most of worki etired)	ng	6b. Kind of Business/Ir Food Lab	ndustry
pu 🥞	d other	Be	17. Father's Name (First, Middle, Last)	N/A O	TIXCE Hall	18. Mother's Name			
ryla E	d Ment marke	ို	Michael Brown  19a. Informant's Name/Relationship (Ty)	na Print) 19h	Mailing Address /St	Dorothy reet and Number or Rura	M. Fell	City or Town State Zi	n Codo)
Baltimore, Ma	permit. Pages 1 and 2 should be tiled within 72 hours after beath with the marylan Department of Health and Mental Hygiene. I Department of Health and Mental Hygiene. I be marked other then "natural", or Itams 23a or 28a-1 show eny injury or other traumatic event, the Mcdital Examiner must be notified at once.		Mrs. Joyce Novak  20a. Method of Disposition  1 □ Burial 2 🖾 Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	20b. Place of cometen	06 Rockf1 Disposition (Name of crematory or other Crematory	eet Road U	nit 301	Timonium. Oc. Location - City or To atonsville	MD 21093 own, State
Baltin	Departme Importer eny injur		21. Signature of Funeral Service License	е	Miller-	ddress of Facility Dippel Fune: lair Road	ral Home	, Inc.	
	nysician /Medical ixaminer		23a. Parti. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	ot enter the mode of	dying, such as cardiac c	r respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (ur as a consequênce of					
vision of Vital Records, P.O. Box 68760,	by the attending phase tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregn 5 ☐ Other (specif			23d. Date of deliver Month	ery Day Year
rds, P	should be delt	by	Part II. Other significant conditions con	e given in Part I.	/	Did tobacco use contribute to the cause of death?  1 Per 2 No 3 Probably 4 Unknown			
Division of Vital Records,	ate has bee	Completed	MACROC		prior to completion of cause of death?				
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ion of	death.	ation; To	27. Manner Death  1	1 ∰Inpatient 2 ☐ ER/Out  28a. Date of Injury (Month, Day Year)  In	ime of 28c.	Cther: 4 Nursing Hor Injury at Work? 1 Yes 2 No	ne 5∐ Residen 28d. Describe how		(y)
Divis	within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, of	fice	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
Div	24 hou a Funer etely fill	edical	29a. Certifier (Check only one) 2 Medicel Exemin	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the	ne time, date and place, a my opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as s e and place, and due to	stated. the cause(s)
Total	within To th	Me	29b. Signature and title of certifier	(		cense number		d. Date signed (Month,	~
	1		70 Name and olderes of	mpleted gauge of death (No. 2001)		0463470		1AY 22	2007
6	V		30. Name and address of person who col RAVITE J ICHW	1001 S	S. HANO'	VER ST. 1	BACTIMO	OR 350	21225
	Sta Registr		31. Date filed (Month, Day, Year) WAY 2 4 2007	32. Registrar's Signature	berte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay Month Year 2007 JACKSON WILLIAM MAY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday Days Hours 216-20-5321 80 1926 Usual Residence of Decedent 10c. City, Town or Location 10h. Count 10d. Inside City Limits MD Baltimore Lansdowne 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2419 Alma Road 21227 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1944If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Senior Project Manager Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Jackson Rose Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June C. Jackson - Wife 2419 Alma Road, Lansdowne, MD 21227 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Mdc Veterans Cemetery Crownsville 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-25-2007 Crownsville, MD 21. Signature of Funeral Service Do + 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CLOSTRIDIUM DIFFICILLY disease or condition resulting in death) Due to (or as a consequence of): 1712 HEIMERIS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more.

sician and burial-transit physician Physician/Medical the as ed by the attending detached for use as signed b þ been signated b Completed has le 2 pade certificate Be ဥ Certification:

the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I.

P.O. Box 68760.

Division or Vital Records,

State

Medical

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

29b. Signature and title of cartifier

MORTHWEST

31. Date filed (Month, Day, Year) MAY 2 4 2007

4 Homicide

(Check only one)

29a. Certifier

determined

6 ☐ Could not be

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 041410

29d. Date signed (Month, Day, Year) 22 n 2007.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHOSPITAL LENTER

JUGINDER P

RAMORUS TOWN

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 17 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 05 16 **Physician** 2007 8:15p.M Willie Ann Johnson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Nursing Home Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 1 F Months Days VΑ 58 **Director** 218-44-2419 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Formities. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 U.S.A. 4127 Forest Park Ave Apt Al Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales Person 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Edwards Willie Junior Morris Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 West Lexington St., Baltimore, Md 21201 Lisa D. Miller-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/22/07 Pikesville, Md Druid Ridge 4 Donation 5 Other (Specify)
21. Signature of Funeral Service Licentee March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Connier worths **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2ÆNo 1 Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) WUSPIU 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 2 No Certification: To After this 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. 24 hours after death Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 🚝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosl within 24 ho
To the Fund Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0 5 8 3 0 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

BAROW

31. Date filed (Month, Day, Year)

2

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2007 4

Division or Vital Records, P.O. Box 68760

6701

32 Registrar's Signature

Charles St

TOWSON MD 21204

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year 17, 2007 11:00 A May <u>Josephine Mae Jonske</u> 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford <u>2513 Franklinville Rd.</u> Joppa If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🛣 F Months Days Hours Min. Yrs. Nov. 2, 1908 Maryland 216-07-3741 Usual Residence of Decedent 98 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Parkville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8820 Walther Blvd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Retailer 8 <u>Sales Person</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Angelina (nmn) Cullotta Salvatore (nmn) Glorioso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2513 Franklinville Fd., Josea, Maryland 21085 Date Date 20c. Location - City or Town. State Louis J. Jonska, Sr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5-23-07 Gardens of Faith Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sidence 6 Other (Specify Residence 1 ☐ Yes 2 🛂 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed and physicien ar s the burial-t P.O. Box 68760 esn Division of Vital Records, certificate this After Hospital

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

.l Hygiene. other than "natural", or items 23a or 28a-1 ahow vent. Itte Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygies Importent: If Item 27 is marked other tt any rijury or other traumatic avent. If any 2006.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29b. Signature and title of certifier

29c. License number 0.35685

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item Blvd, Parkville, MD

31. Date filed (Month, Day, Year) State MAY 2 4 2007 Registrar

4 - Homicide

(Check only one)

29a. Certifier

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ( 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:03 PM Doris M. Knechel 12 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🕅 F Yrs 07/03/1933 Philadelphia, PA Director 208-26-2763 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Bucks Danboro PA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 18916 U.S.A. 4403 Point Pleasant Pike, Box 215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after or Hygiene.

Hygiene...

other than "natural", or itel 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White Completed by 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be bef and Mental Mental Edith E. Grew Edward D. Miller permit. Pages 1 and 2 should Department of Health and Mer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health sem 27 I William Robbins, JR. (son-in-law) 1632 Cass Drive Bel Air, MD 21015 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition any Injury or conce. 1 N Burial 2 □ Cremation 3 □ Removal from State mportant: If 4 ☐ Donation 5 ☐ Other (Specify) 05/18/2007 Dublin, PA St. Luke Union Cem. 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ecc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-tran resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 1☐ Yes 2 No División or Vital director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending l within 24 hours after death. নুo the Funeral Director: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined npletely filled in by 4 ☐ Homicide 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier D0053565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 HOF 250 N TI 32. Registrar's Signatur State mile 4

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day **Physician** wend Z007 Tay /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Hookins Haspita Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 20, 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 □ XF 217-62-1260 52 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show dral Examiner must be notified at MD **Baltimore** 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 West Mosher Street 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyAfrican American Be Completed by 3 ☐ Widowed 4 M Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) medical assistant doctor's office other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H Charles S. Johnson, Sr. Mary V. Jordan ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2618 Maidens Lane; Edgewood, Maryland 21040 Johari Kugenga / Daughter Pages 1 anent of Heart It it item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i 4 ☐ Donation 5 ☐ Other (Specify) Injury Arbutus Memorial Park 05/26/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 'n 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cluse on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) tailure **Physician** iver /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due Physician/Medical Examiner (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 Division or Vital Records, P.O. Box 68760, physician the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a a□Unknown 9 Unknows signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes certificate 1∐ Yes 2 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient No No Medical Certification: To 1 🔲 Yes 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No thours after death.

-uneral Director: A
ely filled in by the fu death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-060

State Registrar The Johns Hoplans
32. Registrar's Signature

Hospital 600 N Wolfe St Brilliam MO 21297

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

tmen

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Agnes C. Laur May 21, 2007 7:20 AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Summitt Park Nursing and Rehab Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 2, 19 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔽 F 217-20-6637 80 1926 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventuals. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland Baltimore 1 ☐ Yes 2 ☑ No Catonsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 Frederick Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 X No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard A. Laur Lena Potthast 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Laur / Brother 754 Yellow Hill Road, Biglerville, Pa. 17307 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20a. Method of Disposition Date 20c. Location - City or Town, State Most Holy Redeemer 5/25/2007 | Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatur of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be execute and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy jo Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? /es 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 **W** 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

6

State Registrar 29b. Signa

address of person who completed cause of death (Item 23a) (Type, Print)

00

29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State		Certificat	te of D	Death				. No.		
Physicia		Decedent's Name (First, Middle,Last						1	Date of Death Month	Day Year	3. Time of 2040	
Exami		Lionel D.	Lindsay				1		May 16, 20	07		1115
		4a. Facility Name (if not institution, give	street and number)			City, Town,		of Death		4c. County o		
		8814 Hawthorne Lane				Washingto		0.011	O. Data of Dint		9. Birthplace (Sta	ate or
Funeral		Social Security Number     6. Se	7. Age (Ir	n yrs. last birtho	′′ -	Months Da	ear If Unde		8. Date of Birti	I(MM/DD/YYYY	Foreign	1
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faryla 28a-f	Director	10e. Street and Number			1	10f. Zip Code	•		10	g. Citizen of Wh	iat Country?	Į
the Na or		221 Bates Stre	et, N.E.			2000				USA		
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ore, MD 21215-0036 ss 1 and 2 should be filed within 721 of Health and Mental Hygiene Titen 27 is marked other than ", her traumatic event, the Medical	H	Lillian J. John		- 11						on, D.C		
ore, MD strand 2 sho of Health and If item 27 is		20a. Method of Disposition		20b. Place o	f Dispositi	ion (Name of			Date		- City or Town, Sta	ate
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ysician		23a. Parl I. Enter the same or com	lications that caused th	e death. Do no	t enter the	e mode of dy	ng, such as	cardiac or	respiratory arr	est, shock, or he	eart Approx	ximate Interval en Onset and
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68760, certificate be nding physic se as the bur	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live birth			al death	3 Ecto	pic pregna	incy	Month	Day	Year
Box (e death ce the attended for use	sici	1 Yes 2 No 9 Unknow	Pregnant at ti	me of death	5 Oth	ner (Specify)				1		
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P.O. Box 687 s that the death certific gned by the attending I e detached for use as the	۾	•	-						1 Ye	es 2 🗸 No	3 Probably 4	Unknown
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tal   cian: certif	l ag	25. Was case referred to medical examiner?	Hospital:	+ 0 FR/C	Outpatient		Other		ng Home 5	Residence 6	✓ Other: Scene	
Physic Physic rthis	P	1 Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of Injur		Time of I		. Injury at W			how injury occi		
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ospita hours mera	ي		ician: To the best of my			rred at the tin	ne, date and	place, and	d due to the ca	use(s) and man	ner as stated.	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending Too the Funeral Director: After this certificate has been signed by the attending Too the Puneral Director nase 2 should be detached for use as	i i	(Check only one) 2 Medical Examin	ner:On the basis of exar	nination and/or	investiga	tion, in my or	inion, death	occurred	at the time, dat	e and place, an	d due to the cause	:(s)
ToT	Modical	29b. Signature and title of certifier	and manner stated.			29c. L	icense numb	per		29d. Date si	igned (Month, Da)	/,Year)
		Joishe J.	Legy n	40			C.M.E.			May 17,	2007	
3		30. Name and address of person wh			)							
V	Î	Tasha Greenberg MD.				Penn Str	eet, Baltiı	more, M	ID 21201			
	_	31 Date filed (Month Day Year)	32. Registra									

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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г	Physici	an.	1. Decedent's Name (First, Middle, Las	1							<ol><li>Date of Dea Month</li></ol>	ith Day	Year	3. Time of Death	
	/Medic		Helen hirsho							05	23	2007	8:34 a M		
Ä	Examin	er	4a. Facility Name (If not institution, give	e street and number)					Location o	f Death			ounty of Death		
			Ridgeway Manor  5. Social Security Number 6. S	7 100	//	think day.	Cator		If Under 2	24 Hrs	O Date of Rid	Ва	ltimor		
	Funeral			ex 7. Age □M 2gdF	e (In yrs. last 88	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Jan. 1	Year)	Cou	pplace (State or Foreig intry) yland	п
	Director		Usual Residence of Decedent								Juli. I	1, 17	IJ Hal	yrand	_
	yland Now		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits	;
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, I're Marice, Exacting mental be rectified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:				Was Deced If Yes, spec	ify Cubar	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
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7	ad wit	Completed	Elementary/Secondary (0-12)			Home	maker					Own	Home		
Maryland	uld be file Mental Hy irked oth	To Be (	17. Father's Name (First, Middle, Last) Charles A. Gree						18. Mothe	_	(First, Middle, L. Jo	Maiden Si hnson			
Man	alth and 2 sho		19a. Informant's Name/Relationship ( Arthur W. Liebn	Type, Print)	- 1		-				A Route Number			ip Code)	
J.	of Her item		20a. Method of Disposition		20b. Place ceme	e of Dispo	sition (Nam	ne of ther place	9)		ate	20c. Loca	ition - City or 1	Town, State	
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687	icate phys s the			_ d										·	
	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	d. Date of deli	very	
Box	atter 1 for 1	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			∃Ectopic pro ∃Other (sp						Month	Day Year	
0		hysi	9 Unknown	9□ Unknown											
<u>ت</u>	The law requires that the tte has been signed by th bage 2 should be detache		Part II. Other significant conditions of	contributing to death be	ut not resultir	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	
rds	quire an sig uld b	pa p	Afrial Kritation								1 🗆 1	′es 2 🗆	No 3 ☐ Pro	obably 4. Honknown	٦
Records,	aw requir as been s 2 should	Completed by	Ald Cerebovacion La	cident							24a. Was		24b. Were au	topsy findings available	е
Re	The lay cate has page 2	E	old Polis.									rmed?	death?	ompletion of cause of 2□ No	
Vital		a)	25. Was case referred to medical						26. Place	of Death	(Check anly a	-	1	20110	_
<u> </u>		To B	examiner? 1 Tyes 2 No	Hospital: 1 Inpatie	nt 2 ER	/Outpatier	nt 3 🗆 DO	A Othe	0F: 4□NG	rsing Ho	me 5 Resid	lence 6	Other (Spec	ify)	
on of	ding h. After fune	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	ry y Year) 28	Bb. Time of Injury	f 2	Bc. Injury Work			28d. Describe h				
Division	l or Attendi after death. Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,	ī	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical Co	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of niner: On the basis of and manner sta	fexamination	edge, deatl	h occurred avestigation,	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c	. License	number			29d. Date	signed (Month	n, Day, Year)	
)	C > F 0		Ditional Rece	Cura			T	196	067			05-	24-20	007	
	3		30. Name and address of person who	completed cause of d	leath (Item 23	3a) (Type,				Is. R.	rine, Ha	_			Į,
	Sta		31. Date filed (Month Day, Year)		ar Signature	e Mc	sucre	1.5	-0. 0	ttu DV	,		-(-)		_
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MAY 21,2007 11:17AM Lawrence Henry Lutkowski /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Towson Baltimore Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 65 Director 118-32-6275 Feb. 7 1942 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show la or 28a-f sh t be notified 1 ☐ Yes 2 X No MD Baltimore Cockeysville Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must 14 Silversage Ct. 21030 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian or items, Black, White, etc. 1▼ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced white "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Pharmaceutical and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adele Artuck Lawrence Lutkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trau Linda L. Lutkowski/wife 14 Silversage Ct., Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5 Other (Specify) Metro Crematory 5/22/07 Catonsville, MD 4 ☐ Donation Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. <u> 10 W. Padonia Rd., Timonium, MĎ 21093</u> 23a. Part1 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only circle actions on each line. Interval Between Onset and Death Immedia: Cause Final disease condition **Physician** VENTRICULAR ARRYTHMIA disease conditions /Medical Due to (or as a consequence of): **Examiner** ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria CORONARY ARTERY DISEASE Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes PERIPHERAL VASCULAR DISEASE 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an RENAL INSUFFICIENCY autopsy perform 1∐ Yes 2 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 2 1 Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After to in by the funeral Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours and To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 5-21-07 LLE MICUUL D31826 841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature OSLER DRIVE TOWSON. MARYLAND 21204 RICHARD 7601 LINTHICUM 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** Blanche 200 7140 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randall 5 tours

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, 1116 DURING BALTIMORE LENTER CHAPEL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 20€F Yrs. 32 0978 MARY Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10a. State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be nutified at once. 1 Yes 2 0 BaltIMOGE Lyndon Director Mary 14-10 10f. Zip Code 10g. Citizen of What Country? 140 40 ROAD 21071 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★6
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 200 Specify: Black ģ 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) triunte Elementary/Secondary (0-12) College (1-4or 5+) Marrica Cook 7 12 gredE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Smith DAVENDONT Margaret Benjamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (73/3 19a. Info, ant's Name/Relationship (Type, Print) Tros 248 DAllastown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₽ Burial 2 □ Cremation 3 □ Removal from State U.H. Church Mary lous Mankton 4 Donation 5 Other (Specify) 21. Signature of Function Service License 22. Name and Address of Facility C NATUR Ax-Horns Bolt wor Ld stown 2/2/1 Tarra Approximate Interval Between Onset and Death 23a. Part1 Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ears Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ♣ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe s certificate has b lirector, page 2 sl 1 ☐ Yes 2 No To the Hospital or Attending Physician: After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 ☐ Yes 2 → No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7007 30. Name and address of person who complited callise of death (Item 23a) (Type, Print)

State Registrar 51-

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32. Registrar's Signature

TIDE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2007 Year May Month Edi th Barbara 22, Lockett 12:50 p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕇 F Days 83 1072/1923 New York 217-16-3782 Yrs. Usual Residence of Decedent 10a. State MD 10b. County N/A 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 Loch Raven Blvd. Apt. 835 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2XXXVo Specify: 3 ☐ Widowed 4 XXDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keerper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Lobdell Edith (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Raymond Lockett / Son 16 Ayr Court Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp 5/23/2007 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee Kimberly Davidson 22. Name and Address of Facility Harford Rd Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Leen Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? disease. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy desease perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, weket, Eath Hospital or Attending **Physician** 

/Medical

Examiner

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Mayda, down at 1250pm

To the Hospital within 24 hours at To the Funeral D

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifie

Am (

29d. Date signed (Month, Day, Year)

Chales St. Balto. Mi 21208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 130 PM 2007 HARLE MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CATONSVILLE BALTIMORE UREST NURSING HOME HAVEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 X M 2 □ F 73 Vre 227-42-0701 Oct 22, 1933 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location worde "netural", or items 23a or 28a-f ehov adical Examiner must be natilled at 1√2Yes 2□No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4017 Liberty Heights Avenue 21215 USA by Funeral unk 12. Was Decedent Ever in U.S Armed Forces? UT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. unk Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk ith and Mental Hygie 27 is marked other r traumatic event, if unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 other tra Haven Nursing Home 4017 Liberty Heights Avenue Baltimore, NO 21215 and Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages Depertment of t important: If its any injury or o once. 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state 21. Sign turn Funeral S. vice Licensee Romand S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 1 Director 655 W. Baltimore Street man. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1 Enter the disease, or compleations that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROSTATE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ THRIVE 4 Dunknown ALLIRE 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes □ No HNAEMIA 24a. Was an autopsy performed 1 Yes 2 No : After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Journing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manuar f Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Man 128595 sueu

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State Registrar TASNEDM

31. Date filed (Month, Day, Year) MAY 2 4 2007 SmITH

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MM 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHANY

2835

32. Registrar's Signature

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nu



Months

Age (In yrs. last birthday)

10c. City. Town or Location

89

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. |

Hours

Battim

Days

10f. Zip Code

2007

4c. County of Death

10g. Citizen of What Country?

Specify.

14. Race - American Indian, Black, White, etc.

Own Home

21085

Month

1 ☐ Yes

Day

24b. Were autopsy findings available prior to completion of cause of death?

Year

Date of Birth (Month, Day, Year)

Sept. 4,1917

Baltimore City

0835AM

9. Birthplace (State or Foreign

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

1X Yes 2 No

Maryland

**Physician** /Medical Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

218-03-6449

Usual Residence of Decedent

10a. State

Maryland

10e. Street and Number

Director

Johns Hookins Barriew Med Cente

1 M 2 K

**Funeral Director** 

the Maryland ral", or Items 23a or 28a-f show Examiner must be notified at "natural", or the Medical Mental of Health and Menta item 27 Is marked r other traumatic er

3511 Esther Place Funeral 21224 death United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 21215-0036 þ 1 ☐ Yes 2 ☒ No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Ernest Flaherty 2 Bessie Maffei 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Martin (Daughter) 17 Court Drive Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any Injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/22/2007 N☐Donation 5 ☐ Other (Specify) Towson, Maryland 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal **Physician** Acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pulmonary Disease be executed roniz obstructive burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death P.O. I 5 ☐ Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed been has 24a. Was an or Vital 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred Division Attending 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 ohns Bayview Hookins 31. Date filed (Month, Day, Year) 32. Registrar's S State MAY 2 4

2007

Registrar

		Please Type or Print in Black In  State of Maryland / Dep  State of Maryland / Dep  Amend #20b Per H C86/ 5/24/07 JH  Calculation of Maryland / Dep				16859
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last)  Robert Albert Norris		2. Date of Death Month May	Day Year 20 200	
Example Funer Direct		Stella Maris         Hospice           5. Social Security Number         6. Sex         7. Age (In yrs. last birthda           219-22-9865         1 ☑ M 2 ☐ F         78	4b. City, Town, or Location of Death  Timonium  y) If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 9	4c. County of Dea  Baltimo (ear) 9. Bir (Car) Cc (928 MD	re hplace (State or Foreign buntry)
vith the Maryland or 28a-f show be notified at	Director	Usual Residence of Decedent   10a. State	sville   10f. Zip Code	10g	j. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fier Z1 is northed other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10 Ivy Hill Ct.  11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  1 □ Ves 2 ☒ No   If Yes, Give Year or Dates:	21030 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - Ame Black, Whit  Specify: wh	e, etc.
Maryland 21215-0036 at 2 should be filed within 72 hours aff tift and Mental Hyglind. To so a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain and a rain a rain and a rain a	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Dec (Giv life.)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)  Mechanic	ing 16	Sb. Kind of Business,  Automot	
yland ould be file Mental Hy arked oth	To Be	Walter Caliston Norris	Gertru	e (First, Middle, Ma de Helen	Ambrose	
Mar and 2 sh lealth and m 27 is m		Robert C. Norris/son 429	Cockeys Mill Rd.,	Reisters	town, MD	21136
Baltimore, permit. Pages 1 ar Department of Hea mportant: If item: my Injury or other		4 Donation 5 Other (Specify)		<del>/07</del> Sp	arks, MD	
Bal permit Depar Impor	ouce.	Diyan W. Clary	22. Name and Address of Facility emmon Funeral Home O W. Padonia Rd.,	limonium,	<u>MD_21093</u>	
Physicia		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  CONGESTIVE HEART I resulting in death)		or respiratory arres	t,	Approximate Interval Between Onset and Death
760, 7 be executed sician and surial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
Records, P.O. Box 687.  The law requires that the death certificate the has been signed by the attending physisage 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
rds, P. quires that n signed by	þ	Part II. Other significant conditions continuously to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac		the cause of death?
al Records,  The law requires t cate has been signe page 2 should be c	Completed			24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
or Vita Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ent 3 DOA Other: 4 Nursing Ho	n <i>(Check</i> o <i>nly</i> one) me 5 ☐ Residend	ce 6 <b>▼</b> lOther <i>(Sp</i> e	cify) HOSPICE
Vitending death.	Certification:	27. Manner of Death  1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 4 Homicide 28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)  28b. Time (Month, Day Year)  28b. Time Injury  28c. Place of Injury - At home, farm, s	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stree City or Town, S	et and Number or Ru	iral Route Number,
Div To the HospItal or / within 24 hours after To the Funeral Dire	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dear of the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caused at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	29c. License number  29c. 25	29d	Date signed (Monti	n, Day, Year)
4		30. Name and address of person who completed cause of death (Item 23a) (Type DR. TARIQ MAHMOOD 2300 DULANEY VALL	e, Print)	MD 21093	J/ 1/	
Regi	State strar	31. Date filed (Month, Day, Year) 32 Registrar's Signature	party			

			1 - For State of Maryland / Department	artment of Health and M		ne007 16860
	Priysio /Med		Ademola Olaiya		2. Date of Death	Day Year 3. Time of Death
	Exam	iner		4b. City, Town, or Location of Death		4c. County of Death
.*	Funera Director		5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1 XM 2 F  50  Yrs.	CHEVERLY If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 01/22/195	
	death with the Maryland ms 23a or 28a-f show Lithual be notified at	Director	10a. State 10b. County 10c. City, Town or Lo	[arlboro		10d. Inside City Limits 1
0036	ĕ 2 2	by Funeral	13118 Ripon Place   12. Was Decedent Ever in U.S. Armed Forces?   13. V   1   Never Married   20 Married   1   1   20 Married   1   1   3   3   Widowed   4   Divorced   1   1   2   3   3   3   Widowed   4   Divorced   1   1   2   3   3   3   3   3   3   3   3   3	10f. Zip Code  20772  Vas Decedent of Hispanic Origin? (Specy Yes, specify Cuban, Mexican, Puerto F		Citizen of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	Mithin hen	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of workin OO NOT use retired)	16b	. Kind of Business/Industry
Maryland 2	2 should be filed v and Menta! Hygie 'le marked other t raumatic event, IL	To Be Co	17. Father's Name (First, Middle, Last)  Akinola Agig Olaiya	Care Worker  18. Mother's Name		
	s 1 and 2 should be filed of Health and Mentat Hyg Item 27 ie marked oths other traumatic event,		19a. Informant's Name/Relationship (Type, Print)	Address (Street and Number or Rural	Route Number, Cit	y or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra once.		20a. Method of Disposition 20b. Place of Dispos	atory or other place)	ate 20c.	Location - City or Town, State  andover, Md
Balt	permit. Departition of the permit of the per		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Mur eorgia Ave. NW Was	ray Funer Shington I	ral Home 4804
68760,	Physician /Medical Examiner ophisician and the primintansit the primintansit ophisician and th	dicai Examiner	Due to (or as a consequence of)	ure protic Cardio		Approximate Interval Between Onset and Death One Mount
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec		ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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Division of Vital Record		Completed	Respiratory Failure vent	h later dependent	24a. Was an autopsy performed?	
ž	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ EB/Outpatient	26. Place of Death (C		
ion of	ding After fune		27. Manner of Death  1 Autural  28a. Date of Injury (Month, Day Year)  2 Accident investigation	3LI DOA 4LI Nursing Home	5 ☐ Residence  d. Describe how inju	6 □Other (Specify) ury occurred
Divis	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 28f	f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
	To the Hosp within 24 hou To the Funel completely fil	Medicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or investand manner stated.	ccurred at the time, date and place, and stigation, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	2 4		29b. Signature and title of certifier  Phulanellbre Gue	29c. License number 001852	AP	ate signed (Month, Day, Year)
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	veensbury Pd1	Hygotsu	He MA 20181
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 2, 4, 2007	2		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 20, 2007 Stockett Odenwald May 11:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care Hammond's Lane Brooklyn Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 12,1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F Director 214-14-0751 86 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow r than "natural", or Itame 23a or 28e-f ahov the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Linthicum 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene. Int: If Item 27 Ia marked other then "natural", or Itame 23a or 2 916 Lynvue Road 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Public Service other treumstic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kuper Odenwald Mary Veronica Stockett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other treu once. Mrs. Mary P. Coppadge/Daughter 605 Elizabeth Road Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 26, 1 Burial 2 □ Cremation 3 □ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1 Second Avenue SW Glen Burnie, MD 21061 M01459 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KNEUMONIA **Physician** WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury Dire to (or as a nonsequence of) Examine physicien and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification; 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 THomicide hours efter within 24 hours er To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b Signature at title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 21, 2007 131136 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RIS, BALTIMORE, MS BRIAN C. WALLALE 9005 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day ELLER 2:10P M **Physician** ARTHUR 2007 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BACTIMORE. RANDALLSTOW CENTER NORTHWEST Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Months Days 1**∑**M 2□ F Nov 23. New York 1928 112-20-0750 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2√ No MD Baltimore Director Reisterstown 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or edical Examiner must be 1010 Dunholme Road 21136 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hr
Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natu
any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) manager laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sophie Yoskowitz Philip Peller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1010 Dunholme Road Reisterstown, MD Claire Peller/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Service ROHALO Palt1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AILURE AEART **Physician** a. CONGESTIVE /Medical Due to (or as a consequence of): Examiner ARPIOMICATE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transi Due to (or as a consequence of) physician a Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 UNGS. CARCINOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nhknown certificate has been si rector, page 2 should Be Completed 24a. Was an autopsy performed? 1∐ Yes 2 ZWo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: Hospital 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 / Inpatient Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. P.O. I Division or Vital Records,

or Attending Physiclan: within 24 hours after death

To the Funeral Director: Hospital the

4 Homicide

29a. Certifier

(Check only

29b. Signature and tiple

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated PHYSICIAM

29c. License number 042723 29d. Date signed (Month, Day, Year)
MAY 19 2007

BOSPITAL 237 m 35 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HARISH 5401 OLDCOVAT

State Registrar

Medical

31. Date filed (Month, Day,

3 2007 \$2. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 200 /Medical Facility Name (If not jnstitution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday, Social Security Number Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 X M 2 ☐ F 9-25-1920 Director 244-20-1445 VA Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 1 ▼Yes 2 No Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or by Funeral 1712 W. LAFAYETTE AVENUE 21217 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 Widowed 4 ☐ Divorced BLACK Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental and Mental LEROY PERRY MARY MONTGOMERY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a VIVIAN MONROE/DAUGHTER BALTIMORE, MD 326 N. PULASKI ST. other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If Ite any Injury or ot once. 1 ☑ Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) KING MEMORIAL PARK 5-24-2007 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. LAURENS ST. BALTIMORE. 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mypute MA /Medical Due to ( as a consequence of) Examiner Sequentially list conditions, it as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? res 2 100 2 No 1 Yes 1□ Yes I or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 🗌 Yes 2 10 1 | Inpatient 2 ER/Outpatient 3 00A 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☐ Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

the Hospital Funeral completely within 24

3

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:18 a M Thelma Peoples May 21, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore** N/A JHH--Bayview Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Director Mar 1, 1934 Virginia 215-28-2852 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1 □ X es 2 □ No notified Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n HSA 21206 23a 5428 Bucknell Road Funeral death 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or Items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and to Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Iten 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 2 Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Beauty Salon** Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Redd Willie James Baskerville ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 5428 Bucknell Road Baltimore, Maryland 21206 Andrea Richardson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Qurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 05/29/07 Baltimore, Md. Loudon Park Cemetery 21. Signature of uneral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 23a. Part1. Enter the disease, or complications that caused the death. shock, or he t failure. List only one cause on each line. Approximate Interval Between Onset and Death onot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause Final disease or condition resulting in death) INFARCTION MYOCARDIAL **Physician** Few hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 OBESITY 21 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PULMONARY HYPERTENSION 24a. Was an autopsy certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation Jopital C.
4 hours after dec.
reral Director: Andre in by the further than the control of the co 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Directory filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Baltimore MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

31. Date filed (Month, Day,

Obah

32. egistrar's Signatula

7-03817 Alvin Parson, Jr.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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:xami	Hei	Alvin  4a. Facility Name (	(if not institution	on, give st	reet and nu	A → mber)		41	b. City, To	wn, or Lo	cation of	Death			4c. County o	f Death	
		University I							Baltimo	ore						Ta più i	(0)
Funeral		5. Social Security	Number	6. Sex		7. Age (In yrs	. last birtho	tay)	If Under	_	If Under	24Hrs.	8. Date o	of Birth(M	M/DD/YYYY	Foreign	ace (State or
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and show	5	MD		A			Balt	lmo	10f. Zip (	20de				10g. (	Citizen of Wi	nat Country	?
Maryl 28a-	Director	10e. Street and N							101. Zip C		.223						
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5-0036 Jed within 7 Hygiene. I other than	0	12th gr			na			Un	emp]	.oye	8.Mother	s Name	(First, Mi	ddle, Maid	ien Surname	empl	oyea
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2121 ould be fil Mental F marked ic event,	To Be	Alvin 19a. Informant's	Parso Name/Relatio	nship (Typ	e, Print )		19b	. Mailin	g Address	(Street	and Nun	ber or R	ural Rou	te Numbe	r, City or Tov	vn, State, Z	ip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. teanth and Mental Hygiene. tenn 27 is marked other than "natural", or items 23a or 28a-f sho fraumatic event, the Medical Examiner must be notified at once.	-	Janet				her	3	0 N	North	ı Go	rma	n A	ve,	Bal	timor	e, M	d 21223
e, N l and Health item		20a, Method of D	Disposition			from State		ory or ot	ther place)				Date		oc. Location	- Gity of TC	JWII, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27; is marked other than "natural", or items 23a or 28a-f show any important: If item 27; is marked other than "natural", or items 23a or 28a-f show any			2 Cremat 5 Other		Removal	K	ing						26/0	7	Randa	llst	own, MD
altin mit. P partme		21. Signature of	Funeral Servi	ce License	ee/ ·			Ma	Name and	Address F/F	of Facilit	st					
B P P II		23/2. Part I. Ente	ua 1	V VA	MON	<i>t</i>		147	รดด เ	Vah:	sh	$\Delta w =$	Ba r respirat	orv arrest	more,	Md eart	21215 Approximate Interval
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Division tal or Attendin rs after death.	l in by	1 Natura 2 Accide 3 Suicide 4 Homic	e 6	Could not determine	be	Place of Injury	_	tarm, s	treet, lacto	ry, onice	: Dullding,	ew.	Unit b	Town, St	ate) man Aven	ue, Baltim	ore, MD
Spital nours neral	filled in	4 Homic	ide			best of my kn		toath oc	curred at t	he time	date and	place, at	nd due to	the cause	e(s) and mar	nner as stat	ed.
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi	pletely	29a. Certifier (Check only one) 2 29b. Signature	Certifyi	ng Physic Examine	r:On the ba	asis of examina	ation and/o	r investi	igation, in	my opini	on, death	occurred	at the ti	me, date	and place, a	nd due to th	ne cause(s)
To T	compl	29b. Signature			and man	ner stated.					nse numb				29d. Date :	signed (Mo	nth, Day, Year)
		11/1	1	11111	11/1	7/				0.0	C.M.E.				May 20	2007	
1		30. Name and	address of no	erson who	completed	cause of deat	h (Item 23a	a)									
5			Brassell,		ssistant	Medical Ex	xaminer	11	1 Penn		Baltim	ore, M	D 2120	)1			
	St	ate 31. Date filed	(Month, Day,	(gar)	2007 3	2. Rojstrar's	Signature	( A	grand.	2							
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Certificate of Death

 Birthplace (State or Foreign Country) Pennsylvania

> 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

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3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

5:40 P M

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	<b>S</b> I		1. Decedent's Name (First, Middle	, Last)									2. Date of De Month		ay	Year	З. Т	Time of Death
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	Examin		4a. Facility Name (If not institution	-		umber)			4b. City,	Town, o	r Location	of Death		4	c. Count	y of Death		
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	Funeral		5. Social Security Number	6. Sex	(	7. Age (	In yrs. las	st birthday)	If Under	1 Year	If Under		8. Date of Bi	rth .		9. Birth	place (	State or Fore
A.	Director		207-10-8394	128	]M 2□F	Ω	8	Yrs.	Months	Days	Hours	Min.	May 5	ау, Үөа. <b>1</b> О	19	Co	untry)	vania
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$\bigvee_{lpha \mid altimore,} lpha$	of He		20a. Method of Disposition 1 ☐ Burial 2X Cremation	о П.		- Ct-t-	20b. Plai	ce of Dispo	sition (Nan	ne of ther plac	ce)		Date	20c.	Location	- City or	Town, S	tate
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.											Onse	val Between et and Death						
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	/Medical Examiner		resoluting in south y			o (or as a					100						31	unth:
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	deal e att		in the past 12 months? 1 □ Yes 2 □ No		4☐Preg	gnant at tir			Other (sp		, 				М	lonth	Day	Year
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<u></u>	r: Te												1 ☐ Yes		No	1 ☐ Yes	2 🗆 N	40
<u> </u>	sician: The k certificate ha rector, page 2	Be	25. Was case referred to medica examiner?	-	lospital:					Oth		of Deat	h (Check only	one)				
5	Phys this al dir	L 2	1 ☐ Yes 2 😿 No	П.	1 _	Inpatient		R/Outpatien		^		ursing Ho	me 5 Res				cify)	
Ę	te fie	ö	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		28a. Date (Mo	e of Injury onth, Day	ear)	8b. Time of Injury		8c. Injur Wor			28d. Describe	how in	lury occu	irred		
Si Si	he sage	cati	2 Accident investig						М	1 🗆	Yes 2	No						
Division of Vital Records,	tel or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Plac	ce of Injury ding, etc.	<ul><li>At hom</li><li>(Specify)</li></ul>	e, farm, str	eet, factory	, office			28f. Location City or To	(Street a	and Num ite)	ber or Ru	ral Rou	te Number,
Q	ital c irs af rai D led ir												at the state of			and the second	Both School	
	e Hospital or Att. 124 hours after de 6 Funeral Directi	cai	29a. Certifier 1 Certifyir (Check only 2 Medical	g Phy Exami	sician: To the	ne best of	my knowl	edge, death	occurred	at the tir	me, date a	nd place,	and due to the	cause(	(s) and n	anner as	stated.	rauso(r)
	o the H lithin 24 o the F omplete	Medicai	one)		and ma	nner state	d.											
	o the	≥	29b. Signature and title of certifie		1 .	X			29c	. Licens	se number			29d. D	ate sign	ed (Monti	n, Day, 1	Year)

30. Name and address of person who person who cause of death (Item 23a) (Type, Print)

1908 Harford Kd

32. Registrar's Signature

B. Parekh MD

31. Date filed (Month, Day, Year)

d place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

D0018424

Fallston

**ORIGINAL** 

MD 21047

DHMH 17 Rev 1/2001

State Registrar

To the

1 - For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VOIZTHWEST RANDA II CE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Days Months Hours Min Director 215.12.4871 83 MARCH 2, 1924 PA Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show be notified at 1 ☐ Yes 2 ☐ No Director MD **BALTIMORE** BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b items 23a Examiner must by Funeral 913 WINSAP CT 21227 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2/🛛 No Specify: If Yes, Give Year or Dates Specify: 3, Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 MACHINIST MANUFACTURING Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Mental ပ JACOB POTTS VERDA ERMINE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **NEPHEW** ROY STEWART 913 WINSAP COURT BALTIMORE, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State any Injury or BAYVIÈW CREMATORY INC 4 Donation 5 Dother (Specify) 5.19.2007 BALTIMORE, MD uneral Service Lice 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT
426 CRAIN HWY S. GLEN BURNIE, MD 21061 21. Signature GREGORY KINK M01148 rations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis Immediate C use (Final disease or condition resulting in deal EUNIONIA **Physician** DIRATED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): P.O. Box 687607 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown RESPIRATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' this certificate Calitie DETOLE Division or Vital 2 100 the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 1 1 Impatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Ďay Year) 1 Natural 5 | Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) certifier

Registrar

DRIANDO

31. Date filed (Month, Day, Year)

MAY

HOSPITAL

MANYLAND

RANDAILS TO NOW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

60

			For State	State of Mar		artment of F rtificate of		1.0		10000
	4.3		Registrar  1. Decedent's Name (First, Middle, Last	)	001	tinicate or i	Death	2. Date of Death	g. No.	3. Time of Death
*	Physici		Pauline G. Ross	•				Month MAY	Day Year /8 2007	1025 M
100	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	111/1-4	4c. County of Death	
	LXaiiiii	) 	THE MEMORIA	L HOSPI	TAL	E	45TON		TALL	307
	Funeral		5. Social Security Number 6. Se	x 7. Age	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
ь	Director		218-05-7271	]M 2√2 F	91 Yrs.	Worth Days		Mar 25,	1916 West	Virginia
122	pu »		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation		<del></del>		10d. Inside City Limits
	sho	5	MD Talb		_	aston				1 ☐ Yes 2√2 No
	the M	ecto	10e. Street and Number	01		10f. Zip Code		10	g. Citizen of What Cou	
	with a or	급	610 Dutchmans Lane				.01			and y :
	eath	Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	216 Was Decedent of H	Ispanic Origin? (Sp	ecity Yes or No-	USA 14. Race - Amer	ican Indian,
10	r Iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		It Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White	
98	urs a	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: wh:	ite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examarer must be positived at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occup	ation during most of work	ina 1	6b. Kind of Business/l	ndustry
2	within 9	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired	d)	9		
2	filed withi Hygiene. other then	Cor	12	5+		writer			journalism	1
Maryland	be fil Ital H Id oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
3	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other treumatic event, the Madical Ergin arright by invitiging all	မှ	Wilmer Plain Pobs		405 Mailli	4-1 /0		eth Mari		i- C- d-)
Mai	12 sho h and 7 is mu treums		19a. Informant's Name/Relationship (7) Easton Memorial H				and Number of Hur. ngton Stre		City or Town, State, Zi	
	1 and Health em 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1		Oc. Location - City or T	
Baltimore,	nt of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		cemetery, crei	matory or other plac	ce)		,	
뜵	permit. Pages 1 Department of H Importent: If Ite any injury or ot		4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of cuneral Service Licens Ronald S	99 1	22	Name and Addre	ss of Facility			
B	Decami Decami Impo any ir		Ronald S.	Nade Dire	ctor	State Ana Baltimore	tomy Boar MD 212	d 655 W.	Baltimore	Street
	- 10.0		23a. Part1. Enter the disease, or comp	ications that caused th	ne death. Do not ent				st,	Approximate
ı	Dhusisian		shock, on heart failure. List only of immediate Cause (Final	ne cause on each line	-1-					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of);	<u>e</u>				days
ı	Examiner			huse	tersur	$\sim$				talling.
		Jer	Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying	Due tr ( r as a	consequence of):					8
	cuted nd ransit	Examin	Cause (Disease or injury that initiated events	c.						
ó	exe en ar urial-t	EX	resulting in death) Last	Due to (or as a	consequence of):				1	
68760,	cate be executed physicien and the burial-transit	dlcal		d						
_			IF FEMALE:	0.0000	-					
Box	death certific e attending p id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy	1		23d. Date of deliver Month	very Day Year
	0 0 2	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death 5	Other (specify)				,
P.0	The law requires thet the de ste has been signed by the a bage 2 should be detached t		Part II. Other significent conditions co	ntnhuting to death but	not resulting in the u	nderlying cause gry	en in Part I	23e. Did tob	acco use contribute to	the cause of death?
Records,	uires the signed d be del	d by	consertie	/	ailure	,,,			s 2 □No 3 □ Pro	
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ž	has has	dm	S with Ma	me	Scandary	TO USHO	DO2020 7	24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
al			dementa					1 ☐ Yes 2	No 1 ☐ Yes	2 🗆 No
of Vital		Be	25. Was case referred to medical examiner?	Hospital:	2	oth Oth	26. Place of Deat			
	Phys r this ral di	To To	27. Manner of Death	28a. Date of Injury	28b. Time o	IL 3 DOA	4   Nursing Ho	28d. Describe hor	nce 6 Other (Spec	ity)
o	iding Phi th. : After thi funeral	flor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear) Injury		k? Yes 2 □ No			
Division	Atter r dea octor by the	Hea	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, st	reet, factory, office			eet and Number or Ru	ral Route Number,
Ö	s afte	Certification:	4  Homicide	building, etc.	(арвспу)			City or Town,	Jidle)	
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of	my knowledge, deat	h occurred at the tir	me, date and place,	and due to the ca	use(s) and manner as	stated.
	he Hin 24 he Ft pletel	Medical	one)	ner: On the basis of e and manner state	xamination and/or in id.	vestigation, in my o	ppinion, death occur		ite and place, and due	
	To t To t	Σ	29b. Signature and title of certifier	1 /1	/	29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
			1/100	1.100	who is	0	4043	//	ray 18,	400/
			30. Name address of person who c	ompleted cause of dea	ith (Item 23a) (Type,	Print)	0 .	0, 5	-1 1	1 2 1

Registrar

31. Date filed (Month, Day, Year)
MAY 2 4 2007

32 Registrar's Signature

ROSS, PAULIUZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RECA **Physician** JOSEPH 4:10 AM MAY 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ItOS PITAL RANDALLSTOWN NORTH WEST BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 31 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F Months Days Hours Min. PA Director 192-14-7686 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Gwynn Oak 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2600 West Park Drive 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYPes 2 No
If Yes, Give
Year or Dates: 43–49 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer <u>Westinghouse</u> of Health and Mental Hygie If Item 27 Is marked other I or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor Reca ဥ Anna Zygmont 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Reca - son 3812 Bayville Road, Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If Itel
any Injury or ott 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 5/30/2007 Baltimore, MD 21. Signature of Funeral Service Licensee Steven H 22. Name and Address of Facility Mac Nabb Funeral Home, P.A. Williams 301 Frederick Road, Catonsville, MD Hull 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> PNEUMONI 2X No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 X No certificate 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L the Hospital XertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DSTTZZ 2007 MD 170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARD RICHARPSON M.D. 1838 GREEN TREE ROAD #300 PIKESVILLE MD, 21208 31. Date filed (Month, Day, Year) 3 Registrar's Signature State MAY 2 4 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	S	state of	Marylan	•			lealth a D <i>eath</i>	and M	1ental Hyg	giene () ()	-	16070
			1. Decedent's Name (First, Middle	Last)								2. Date of Dea Month	ath Day	Year	3. Time of Death
ы	Physici /Medio		Mary Elizabe	th R	ausch							May		2007	4:20 A M
	Examir	-	4a. Facility Name (If not institution,	give stre	et and num	ber)		4b. City,	Town, or	r Location of	of Death		4c. County	of Death	
188			Manor Care							seda1		T			imore
	Funeral			<ol> <li>Sex</li> <li>1 □ M</li> </ol>	2 <b>∏</b> F 7	'. Age (In yrs.	last birthday) Yrs.	Months Months	Days	If Under Hours	Min.	8. Date of Birtl (Month, Day	h y, Year)		place (State or Foreign intry)
	Director	Ø.,	217-01-8860 Usual Residence of Decedent		-X	89	115.					March 2	29,1918	M	aryland
	and		10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	f sho	5	Maryland Rali	imoı	60			Per	ry H	Ia11					1 ☐ Yes 2 No
	the t	Directo	Maryland Balt	LINOI		1		10f. Zip					10g. Citizen of \	What Cou	intry?
	with with		9808 Richlyn D	<b></b>					21	236			IT	. s.	Δ
	n 72 hours atter death with the Maryland "natural", or Iteme 23a or 28a-f show salcal Esaminar must be notified at	Funerai	11, Marital Status		Was Deced	ent Ever in U	I.S. 13.	Was Dece			gin? (Sp	ecify Yes or No- Rican, etc.)		e - Ameri	ican Indian,
	r lter	臣	1 ☐ Nøver Married 2 ☑ Marri	ed	Armed Ford	2 <b>∑</b> No						Rican, etc.)		ck, White	, etc.
ဗ္ဗ	urs a	by	3 ☐ Widowed 4 ☐ Divorced		If Yes, Give Year or Da	,		1 🗌 Yes	2X No	Specify:			Specify	v: Wł	nite
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nd	should be tiled nd Mental Hygi marked other imatic event, II	Be (	17. Father's Name (First, Middle, I									e (First, Middle,		n <i>e)</i>	
Maryland	Ment Ment arke	2	Thomas McLaugh	1in						E	liza	beth Wa	tkins		
lan	a se se		19a. Informant's Name/Relationsh	ір <i>(Турв,</i>	Print)		19b. Maili	ing Address	s (Street	and Numbe	er or Rui	al Route Numbe	er, City or Town,	State, Zi	p Code)
	C = N -		Thomas Rausch	(Son	)	7.1					rt,	Bel Air			
altimore,	ges 1 and t of Healt if Item 2 or other i		20a. Method of Disposition 1 □ Burial 2 🎇 Cremation	3 ⊟Rem	noval from S	20b. I	Place of Dispo cemetery, cre	osition (Na matory or c	me of other plac	ce)		Date	20c. Location	- City or T	own, State
<u>Ĕ</u>			4 □Donation 5 □ Other (Sp				ayview								Maryland
alt	permit. Pag Department Important: sny Injury once.		21. Signature of Funeral Service I	icens <i>ee</i>	0 .	1-	2	2. Name a	nd Addre	ss of Facili	y Sch	nimunek	Funera1	Hom	es,
<u> </u>	89 = 9		Dufane	2	Kun	ere	) 9	705 B	elai	r Roa	d, I	Baltimor	e, Mary	land	21236
100 m			23a. Part1. Enter the disease, or shock, or heart failure. List	complicationly one	tions that ca	used the dear	th. Do not en	ter the mod	de of dyir	ng, such as	cardiac	or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-		Poop	rem	~	De	cely	ne				Onset and Death
	/Medical		resulting in death)	•	Due to (c	or as a consec	quence of):			0	1		2		
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4	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (c	or as a consec	quence of): A	1.		0.0	30	1			
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Ö,	e exe	ĕ	resulting in death) Last		Due to (c	or as a consec	quence ot):								
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9	eath certifica attending ph I tor use as th	Mec	IF FEMALE:	7=010											
Вох	ath cert ttendin or use	an/	23b. Was decedent pregnant in the past 12 months?	23c.	1 Live bir	ome of pregn th 2 ☐ Feta	aldeath 3	□Ectopic p		,				ite of deliv onth	very Day Year
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of V	S 5	ဥ	1 ☐ Yes 2 ☐ 110				ER/Outpatie			4 (2 IVI	ursing H	ome 5 Resid	dence 6 □Oth	ner (Spec	ify)
			27. Manner of Death 1 ☐ Natural 5 ☐ Pendin		28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury		28c. Injur Wor			28d. Describe I	how injury occur	rred	
Division	Attending r death. ector: After by the tune	Certification:	2 ☐ Accident investig	ation				М	1 🗆	Yes 2	No				
≅	or Att	į	3 ☐ Suicide 6 ☐ Could in determ			of Injury - At h ig, etc. (Speci		treet, factor	y, office			28f. Location (S City or Tox	Street and Numi wn, State)	ber or Ru	ral Route Number,
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15	1		30. Name and address of person			- 1	m 23a) (Type	Print)	171+	TLIAL	PI	2000 800	nte 308	131	attimore.
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	Sta Regist	ate	31. Date filed (Month, Day, Year)  MAY 2 4	2007	Mar	ryistiai's Sign	, ule	els)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 30 M **Physician** ma 20 2007 Joseph M. Regler, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Levindale If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days
Min. (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 80 May 09,1927 219-22-0195 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County at 1 X Yes 2 □ No r 28a-f sh notified Ocean City Maryland | Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or r 21842 U.S.A. 107 Convention Center Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner mu Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Clerk U.S. Postal Service I and 2 should be filed wi Health and Mental Hygien Im 27 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna M. Rodenberg Joseph M. Regler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is 107 Convention Center Drive Ocean City, MD 21842 Jacqueline Regler (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Garrison Forest VA May 23,2007 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee a Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 15min /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examiner burial-trar Due to (or as a consequence of): physician Physician/Medical the ! as 1 IF FEMALE: for use a If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊟tinknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops) perform 1 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 this 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ...al or At.

ours after deat.

al Director: At.
in by the fur 1 🗂 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Box 68760.

P.O.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Mac 2007 320 Herman Clifford Reiher 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 712 Idlewild Road Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Hours 1**X**M 2□F Yrs 470**-**30-9308 76 7, 1931 Feb. Minnesota Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Idlewild Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Aeronautical Engineer Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) (unk) (unk) (unk) (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Reiher /Son 607 Foxcroft Dr., Bel Air, Maryland 21014 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 5-22-07 Towson, Maryland 21. Signature of Juneral Service <sup>22</sup> McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

The law requires that the death certificate be executed

Hospital or Attanding Physician:

To the within 2

death. after death

24 hours a

After this

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Division of Vital Records, P.O. Box 68760

important: if itam 27 is any injury or other

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

Director

itam 27 is markad other than "natural", or itams 23a or 28a-f show othar traumatic svant, the Madical Examinar must be notified at

d 2 should be filed within 72 ih and Mental Hygiene." 7 is markad other than "na

the Maryland

Examine Physician/Medical þ

the attending physician and hed for use as the burial-transit Completed 0 Certification: filled in by

27

Medical

IF FEMALE:
23b. Was decedent pregnan
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 Unknown
Part II. Other significant cor

Dart II Other significant condi	triang annulls, standards but not an object to the standard of
	itions contributing to death but not resulting in the underlying cause given in Part
1	None a

None	

230.	Did toba	cco u	se cor	tribute to the cau	ise of death?
	1 🗌 Yes	2	No	3 🗌 Probably	4 □Unknowr
24a.	Was an autopsy		24b.	Were autopsy fir prior to completion	ndings available

☐ Yes

					performed?  1 Yes 2 No	1
25. Was case referred to medical examiner?			26	6. Place of Death (Ci	heck only one)	
examiner? 1'Yes 2□ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA Other:	4 Nursing Home	5 Residence	6 Oth
27 Manner of Death	28a Date of Injuny	28h Time of	29a Inuni at		Deparibe how injur	

1 Yes 2□N	0	1 Inpatient 2	☐ ER/Outpatient	3 🗆 D	OA Other: 4	Nursing H	lome 5X Residence 6 □Other (Specify)
Manner of Death 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street ify)	, factor	ry, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 Certifying Phy
(Check only	2 Medical Exem

29t	. Signature and title of co	ertifier		
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	Junara	HAMME	14/1/1	INL
-			total disease	-1 -1 -1-1

path (Item 23a) (Type, Print) = 1614 CHGRCHVIILE WAS BEL AIR Md ZR	 De0 14206	N	Day 21, 200	7
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29c. License number

290. Date	signea	(MONU),	Day,	rear)	
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Registrar

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		n, IV State of Maryland / Departme	ate of Death	Reg. N	o	
	Re	gistrar Decedent's Name (First, Middle,Last)		2. Date of Death	/ Year	3. Time of Death 2115 hrs
Physicia xamin		Thomas Francis Regan, IV		Month Day May 14, 2007	4c. County of Death	
		. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	٦	Anne Arundel	
		490 North Patuxent Road # 44	Odenton  If Under 1 Year   If Under 24Hr	2 Date of Birth/M	M/DD/YYYY) g. Bir	thplace (State or
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24Hr  Months Days Hours Min		Foreig	untry) Mass.
Director	12	17-84-6146 1XM 2 F 46	Yrs.	NOV 29,	1900 0	riass.
		sual Residence of Decedent  10c. City, Town	or Location			10d. Inside City Limits
any	1	Ja. State				1 X Yes 2 N
and show	5 I	Maryland Anne Arundel	Odenton  10f. Zip Code	10g. (	Citizen of What Cou	intry?
daryl:	Director	0e. Street and Number	·		United	States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland pepartment of Health and Mental Hygiene. Important: I fitten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		490 North Patuxent Road	21113  13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ame	rican Indian, Black,
h with	uneral	1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? Armed Forces?	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	
deatl or ite	핊	1 A Yes 2 No	1 Yes 2 X No specify:			White
s after	δ.	3 Widowed 4 Divorced II Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	Penadont's Liquid Occupation (Give kind o		b. Kind of Business	/Industry
hour:		Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	etired)		
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e, land land Healt litem		20a. Method of Bisposition	atory or other place)	ļ		
nor ages ent of nt: If		1 Burial 2 XCremation 3 Removal for State 4 Donation 5 Other Specify: West	Arundel Crematory 5	/23/2007		Maryland
nit. Fartment outside		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Donaldson Funeral 1411 Annapolis Ro	Home & Ci	rematory,	P.A.
Der Der Injin		Vehilla M00773	1411 Annapolis Ro	ad Udento	t. shock, or heart	Apploximate into
/sician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such as cardia	acor roop. acory	, ,	Between Onset a Death
ledical		Immediate Cause (Final disease a Chest Injuries				
Examiner		or condition resulting in death)  Due to (or as a consequence of):				<u> </u>
	_	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):				
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68 ertifi	Physician/Me	past 12 months?  4 Pregnant at time of death	2			
- 5 = 5	ysic	1 Yes 2 No 9 Unknown 9 Unknown		Loo- Did tol	bacca use contribut	e to the cause of death
Sox   leath or e attend for use	님	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I			Probably 4 🗸 Unkno
C. Box 68760 true death certificate by the attending physisched for use as the bh		<b>i</b>			2	
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Division of Vital Records, P.O. the Hospital or Attending Physician: The law requires that the nin 24 hours after death.	filled in by the i	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29. Certifier . □ Out this Physician. To the best of my knowledge.	R/Outpatient 3 DOA Other4 No. 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 ✓ No. 2105 hrs ne, farm, street, factory, office building, etc.  Redeath occurred at the time, date and place of the investigation, in my opinion, death occurred.	24a. Was a autopuperfor 1 Version 1	Residence 6 Common injury occurred  Street and Number of State) ent Road, #44, Octoor and place, and due	e autopsy findings avair to completion of cause th? Yes 2 N Other: Scene  or Rural Route Number denton, Md s stated. to the cause(s) (Month, Day, Year)
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Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Direction: After this certificate has been signed by	y filled in by the I	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 2)	R/Outpatient 3 DOA Other4 No. 28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No. 200 No. 20	24a. Was a autop perfor 1 Version 1	Residence 6 Common injury occurred  Street and Number of State) ent Road, #44, Ocese(s) and manner as and place, and due	e autopsy findings avair to completion of cause th? Yes 2 N Other: Scene  or Rural Route Number denton, Md s stated. to the cause(s) (Month, Day, Year)
Division of Vital Records, P.O. the Hospital or Attending Physician: The law requires that the nin 24 hours after death.	y filled in by the I	25. Was case referred to medical examiner?  1	R/Outpatient 3 DOA Other4 R/Outpatient 3 DOA Other4 R/Outpatient 3 DOA Other4 R/Other4 R/Othe	24a. Was a autop perfor 1 Version 1	Residence 6 Common injury occurred  Street and Number of State) ent Road, #44, Ocese(s) and manner as and place, and due	e autopsy findings avair to completion of cause th? Yes 2 N Other: Scene  or Rural Route Number denton, Md s stated. to the cause(s)  (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Roberts 12:05A M Elizabeth C. 2007 May 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Co. Gilchrist Center If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 3 XXF 85 135-16-0356 Director May 23, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2(XNo Dundalk Director Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8224 Longpoint Road United States 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Psychic <del>7 Years</del> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Dangerfield Augustis Cusick ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: if Item 27 is
any injury or other trau 8224 Longpoint Road Dundalk, Maryland 21222 Angel M. James (Granddaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem.5/23/2007 Dundalk, Maryland Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 24 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ distant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No certificate has 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence Cother (Specify) No > P(O ို 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mary

Registrar
DHMH 17 Rev 1/2001

State

6701

N.

Charles ST TON UN MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2007

J. CHALVES, NO

32 Registrar's Signature

AARON

31. Date filed (Month, Day, Year)

1			1 - For State Registrar	State of Maryland		rtment of He tificate of D			iene () ()	7	16875
	Physici /Medio		1. Decedent's Name (First, Middle, Last EDWA RD S	atchell				2. Date of Death Month	Day	Year 007	3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give Harborside Garder  5. Social Security Number 6. Se 219-30-6701	ıs	t birthday) _ Yrs.	4b. City, Town, or I  Baltim  If Under 1 Year  Months Days		8. Date of Birth (Month, Day, July 8,	4c. County  Year) 1931	9. Birthp	place (State or Foreign
	D	ctor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, T	own or Loc			July 6,	1931		yland Od. Inside City Limits 1X Yes 2 □ No
	h with the 23a or 28 st be no	al Director	10e. Street and Number 4700 Harford Road			10f. Zip Code	1206	10	g. Citizen of V		itry?
036	d within 72 hours after death with the Maryland Jiene. r than "neturel", or Items 23a or 28e-f show Itte Macilical Examinet rust be notified at	by Funeral	11. Marital Status  1    Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cuban ☐ Yes 2X No	panic Origin? (Sp. Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race	- Americ k, White,	
9500-61212	within ene. then	Completed	15. Decadent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+)  O	(Give k life. D	ent's Usual Occupat ind of work done du O NOT use retired) abled	ion ring most of work	ing	6b. Kind of Bu		fustry
yland	be filed tal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last)				8. Mother's Name	e (First, Middle, N			unk
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ie marke any injury or other traumatic once.	L	Dorothy Griffin/c  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 ☒ Other (Specify)	aregiver  aremoval from State  in a state of the state of	4921 e of Dispos etery, crem	Address (Street an Queensbur ition (Name of atory or other place)	y Avenue	Baltimo	ore, MD Oc. Location	212 City or To	216 wn, State
n D	perm Depa Impo any i		21. Signature   uneral serve Licens   Rona   S. V	ade Director	Da.	Name and Address ate Anator Ltimore, N	ער עוי	L		re S	Approximate
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conservient	ce of):	raest nal c	liseas		31,		Interval Between Onset and Death
,09/80,	artificate be executed ing physician and e as the burial-transit	edical	resulting in death) Last	Du o for as a consequend							
.O. BOX	The law requires that the death certiste has been signed by the attending sage 2 should be detached for use a	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □E	ctopic pregnancy Other (specify)			23d. Date Mon	of deliver	ry Day Year
ecords, r	equires tha sen signed l	ieted by P	Part II. Other significant conditions cor	tributing to death but not resultin	g in the und	derlying cause given	in Part I. Nentia				e cause of death?
	an: The law ificate has b or, page 2 sh	e Compie	25. Was case referred to medical				D. Dissert Devil	24a. Was an autopsy perform	ed2 de	/ere autoprior to comeath?	osy findings available inpletion of cause of
VISION OF VI	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after feath, within 24 hours after feath. To the Funeral Director: After this centificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ertification; To B	examiner?		Outpatient o. Time of Injury	3□ DOA Other: 28c. Injury a Work?	4 Nursing Hor	n (Check only one me 5 ☐ Resider 28d. Describe hov	ce 6 □Othe		)
	vital or Atte	0	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (Stre City or Town,	State)		
	thin 24 house thin 24 house the Fune mpletely fi	Medical	29a. Certifier (Chack only one)  2□ Medical Examination  29b. Signature and title of certifier	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death of and/or inve	stigation, in my opin	ion, death occurre	ed at the time, dat	e and place, a	nd due to	the cause(s)
	S 7 8 7	7	30. Name and address of person who co	mulated course of doubt the course	a) (T	64	493		5 - 16		
	Sta	te.	30. Name and address of person who co	82 N. Eurou  3. Registrar's Signature	N SC		308, P	Baltine	one 1	n03	2/20/
	Registra		MAY 2 4 200	1 Marian St	4004	CA.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Year Mildred L. Sullivan 9:00A M ay 2007 /Medical County of Death 4a. Facility Name (If not institution, give street and number) Examiner timore Da venetro 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 081-01-8128 92 Director 1915 New Jersey Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 709 Maiden Choice Lane 21228 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 7 Is marked other than "natural", or items traumatic event, the Medical Examiner me 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Pipe & Steam Fitters permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporant: If Item 27 Is marked ofth any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Ludewig Marie L. Klein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 455 Frysville Road York, PA 17406 Richard J. Sullivan, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/24/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) heimer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of certificate be executed attending physician and for use as the burial-transi P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 -NO 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 Yes 2 No 3 Probably 4 Junknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 autopsy performed 1□ Yes 2 3NO ospital or Attending Physician: I hours after death. uneral Director: After this certificat iy filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Hoursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Tyes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C the Hospital 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) 30. Hame and address of Jerson who completed cause of death (Item 23a) (Type, Print) 10 Year) State 2007 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2007 /Medical 123 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LTIMETE LOACHTH GrOW MEDIZAL CENTES ANNB AKIMDEI If Under 1 Year Months Day 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 212-92-2102 29 Hours Min. 1 ☐ M 2 🕶 F Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1timore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use jetired) the Medicai 15. Decedent's Education (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4or 5+) LYN is marked other Father's Name (First, Middle, Last, Maryland Be Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joiner Hanover, MD 21076 Baltimore, 20b. Place of Disposition cemetery, crematory Method of Disposition Date 20c. Location - City or Town, State Important: If its any injury or o 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Servicer License Services Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. . Nat I Yike, Balto, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METACTATIL **Physician** GOLON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to transdict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mis 2007 and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth Year **Physician** George Jacob Schaeffer III 2007 1:35 PM 21 May /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner Cockeysville Baltimore MD Masonic Homes If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days X□ M 2□ F Months Yrs. 216-30-8306 75 Director MD July 20 1931 Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Cockeysville 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 300 International Circle Funeral 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X☐ No Specify: Completed by 55-158 3 € Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Georgetta Dawson George J. Schaeffer, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7793 Fort Valley Rd., Ft. Valley, VA 22652 Amy Wilson-Payne/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ☐ Dopation 5 ☐ Other (Specify) 5/23/07 Catonsville, MD Metro Crematory 21. Signature of Funeral Service License e 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Lowell M. Lemmon 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) PARKINSON'S DICECTE Examiner Due to (or as e consequence of) Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uaa contributa to tha cauaa of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 💆 No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 15 Cartifying Phyalclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bank

8508

32. Registrar's Şignature

411

To the Hospital within 24 hours a To the Funeral Completely filled

spital or Attending Physician: The law requires that the death certificate be executed outs after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 💪

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OROTH Month 05 **Physician** CHLOTZHAUER 0825 (m. 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEVERN

If Under 1 Year | If Under 24 Hrs.

Hours | Min. 7950 TELEGRAPH RD. Lot 83 ANNE ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 7 F Director 82 DEC 24 , 1924 MD 218.24.7417 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director MD ANNE ARUNDEL **SEVERN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7950 TELEGRAPH RD Funeral Lot. 83 21144 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽ No WHITE þ Specify: Specify: 3 ☐ Widowed 4 ☒ pivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 **LABORER** WESTINGHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ LEONARD ABBOTT PEARL POOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important; If Item 27 any Injury or other trong once. DIANE SHULSKI DAUGHTER Lot83 SEVERN MD 7950 TELEGRAPH RD. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 □ Donation GLEN HAVEN CEMETERY MAY 25, 2007 GLEN BURNIE, MD 21. Signature i e i s 22. Name and Address of Facility FINK FUNERAL HOME, P.A. K. CRECOR FIN M01148 426 CRAIN HUY. S GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 /Medical Due to (or as a consequence of Examiner Ce Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%burial-tran Due to (or as a consequence of): physician attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 honths? Year Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe 1∐ Yes 25 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home FResidence 6 Other (Specify) Certification: To 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 S CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I To the 29b. Signature and title of certifier / Charl 29c. License number 29d. Date signed (Month, Day, Year)

h State

31. Date filed (Month, Day, Year) MAY Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D., Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD 32. Registrar's Signature 2007▶

Chief Medical Office

D 21438

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 21, **Physician** 2007 Thomas Page Sharman 4:20 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3624 Bellevale Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 □ F 220-09-6986 85 25, 1921 Maryland Director Nov. Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County MD N/A Baltimore 1x Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a o must b 3624 Bellevale Avenue 21206 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. Instit if item 27 is marked other than "ratural", or items 23, mit; if item 27 is marked other than "ratural", or other traumatic event, the Medical Examiner must any or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Car Carrier 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Preston Harry R. Sharman ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Sharman- Wife 3624 Bellvale Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National Cem 5/25/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Baltimore, MD 21206 23a. Fart . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr. st sho k, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm die e Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner physician and s the burial-trans attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to leath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical examiner? Be

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

the Maryland

with

Baltimore, Maryland 21215-0036

certificate has birector, page 2 s ို after death.

I Director: After this d in by the funeral d Certification:

this

within 24 hours a To the Funeral I

Medical

1 ☐ Yes

27. Manner of De. Natural 2 Accident

Division or Vital Records, P.O. Box 68760,

26. Place of Death (Check only one)

1 ☐ Yes 2 N	0	Hospita	tal: 1	ER/Outpatient	3 🗆 [	Oth	er: 4	☐ Nursing H	ome	5 Aesidence	6 □Other (Specify)	
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3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286	ie. Place of injury - At he building, etc. (Special	ome, farm, stree fy)	t, facto	ory, office			28f. l.	ocation (Street a City or Town, Sta	nd Number or Rural R e)	oute Number,

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inversal manner stated.		
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

Enth thusell

31. Date filed (Month, Day,

State Registrar

		-	For State Registrar		State	of Mar	ryland		rtmen tificate				lental Hy	giene Reg. No.	00	7	1588	
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	Examine	_	4a. Facility Name (If no			iumber)			4b. City,	Town, or	Location of	of Death		4c.	County of	Death		
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	and and	1		Ob. County		1	10c. City,	Town or Lo	cation							1	0d. Inside City Lim	nits
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39	permit. Pages Department of Important: If it eny injury or o		21. Signature of Fund	ral Service Lic	ensee			> 22	Cha	rles	S. Z	Zeile	er & Sc enue E	n, I	nc.	MD	21224	
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Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4  Homicide	determin	bu bu	ilding, etc	. (Specity)						City or T	own, State	•)			
	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 (Check only 2 one)	☐ Medical E	Physician: To caminer: On the and m	the best of e basis of nanner state	exa <i>m</i> ination	ledge, deat on and/or in	n occurred ivestigation	at the tive i, in my o	ne, date a pinion, de	ind place ath occu	, and due to th rred at the time	e cause(s e, date an	) and <i>m</i> ar d place, a	nd due i	stated. to the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 1435 4 Wa 2007 ornes /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS STAROT M-CIT Ine orc If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day If Under Year Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🔀 F 219-53-5871 1-6-1999 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2334 Druid Park Drive SA U Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. ☐ Yes 2X No f Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XDXNo Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry NA 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NA Elementary/Secondary (0-12) College (1-4or 5+) Student 2nd grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Thomas ပ္ Tracey Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Jones-Mother 2334 Druid Park Drive Balto, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 5-24-07 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West donald Wabash Avenue Balto, MD 21215 4300 ntl. Enter the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death mediate Cause (Final Physician disease or conductive resulting in death) DITYOU /Medical Due to (or as a consequence of): Examiner Near Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Drownin Due to (or as a consequence of) Examine death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Prevnothorax 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred Loss of consc under wat 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation consciousness 1 Natural Injury 7:55 PM 2 Accident 3 ☐ Suicide 05-11-2007 1 Yes water. Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 The Property of Communication of Communicatio 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide wimming 24 hours a Funeral I Hunt 00 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

0

one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

within 24

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

MAY 2 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Gustavo Antonio Tochoy 13, 2007 12:30 P M May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Fallston 1107 Wild Orchid Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Director 65 3, 1942 Columbia 214-54-5162 Feb. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō items 23a 21047 U. S. A. 1107 Wild Orchid Dr. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 9 1

Yes 2

No Specify: Specify: Columbian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Graphic Artist Printing injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Lucilla Dugve Narciso Tomoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any injury or other trau 1107 Wild Orchid Drive, Fallston, Maryland 21047 Berta Tochoy (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 05/ 17/2007 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Completed by Physician/Medical WEUrusm IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 🔰 No

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O.

within 24 hours after death. To the Funeral Director: After ö

Medical State Registrar

27. Manner of Death

1 Natural

3□ Suicide

29a. Certifier (Check only one)

29b. Signate

2 Accident

4 Homicide

31. Date filed (Month, Day, Year)

4

5 Pending investigation

6 Could not be determined

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and minner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

23a) (Type, Paint)/ing Cross Road, Battinsre, Md 21228

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28a. Date of Injury (Month, Day Year)

32. R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2: 23 am **Physician** ELVIN 07 may 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 № M 2 □ F 63 40 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Inst. If Item 27 is a marked other than "natural", or Items 23a or 28a-f show must. If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1. Yes 2 No Director BAIHHOR MAY ISNO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US17 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ To If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify. Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 ☐ Widowed 4 Dovorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CAB Ci. Elementary/Secondary (0-12) College (1-4or 5+) rIVEV 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be USEPL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 UMU 9 hoter Ad 21216 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. YATVICIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 23/67 → urial 2 □ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facil 5240 Less Torskus alikes 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) left **Physician** days hemorrhagic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9□Unknown 9 Unknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by hypertension 2 No 3 Probably 4 ☐Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 🗖 certificate Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours at er death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar Equal Alsheikh

Fund

31. Date filed (Month, Day, Year)

MAY 2 4

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alsheikh,

2007

900 SCaton Ave.

32. Registrar's Signature

P20966

Baltimore, MD, 21229

May, 16, 07

			For Stata Ragistrar	1 10400			d / Depa		t of H	ealth a	and M		giene Rag. No.	007	Î	1688	35
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	/Medic		Robert N									May 15				2:15 P	M M
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<u>7</u>	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or flems 23a or 28a-f ahow do other than "natural", or flems 23a or 28a-f ahow event. The Medical Examinar must be notified at	Completed	(Speci		Education trade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	k done a	lurina mos	t of work	ing	16b. Kii	nd of Busine	ess/Indu	ustry	
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Balt	permit. Page Department o Important: If any injury or once.		21. Signature of	eral Service Lic nald	Wade A	ecto1	s St	Name and a late A	d Addres Inato	s of Facili Dmy B MD	oard 2120	655 W.	Ba1	timor	e St	treet	
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<u>,</u>	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) L	•	c. Due to (	or as a conseq	uence of):								=		
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68	ntifica ng ph as th	Medi	IF FEMALE:													-	100
P.O. Box	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	23b. Was decedent in the past 12 in 1 Yes 2 Such as 2 Unknown	nonths?		rth 2 ☐ Feta ant at time of d	Ideath 3□	⊒Ectopic pro ☐ Other (sp					2	23d. Date of Month		•	эаг
<u>.</u>	that the ad by detacl	F.	Part II, Other signifi	cant conditions	contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did	tobacco u	se contribut	te to the	e cause of dea	ath?
Vital Records,	quires an sign uld be	ed by										10	Yes 2[	]No 3[	] Proba	ably 4 □Un	iknown
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Division of	Attending Physicien: r death. ector: After this certific: by the funeral director.	lon	27. Manner of Death 1 ☐ Natural	5 Pending		h, Day Yeer)	28b. Time of Injury	т 2 М	8c. Injury Work	rat ⊲? Yes 2. 🗆		28d. Describe	now injur	y occurrea			
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	To the Hospital or Attending Ph within 24 hours atter death To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)		Physician: To the aminer: On the ba	sis of examina											
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** war 05 IOAM John 11 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hlice manor nursing Horme If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept 4, 1918 If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1⊠M 2□F 88 Director 218-05-6492 Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after deeth with the Maryland nant of Heelth and Mantel hygiene.
ant: If item 27 is marked other than "naturel; or items 23s or 28s-f show ury or other treumetic event, it's Medical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No Funeral Director MD Baltimore 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 2500 W. Belvedere Avenue #517 21215 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: black Š Year or Dates: 144-45 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 mailings postal clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B Henrietta Cornelia Johnson John Thomas Ward Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 W. Belvedere Avenue #517 Baltimore, MD Ruth E. Ward/spouse 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: If eny injury or 4 Nonation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death \Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the deeth certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, norther 1 rachin Due to (or as a consequence of): Obstractive Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐-Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? edical Certification: To Be Completed TLI Yes 2 NO 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funerel Director: After this certifics complately filled in by the funerel director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Ho 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. ENTAW of Jinte 200 BALTIMOREMA 2120

Registrar **DHMH 16 Rev 6/95** 

State

SHOALB A. HASHMI MD.

MAY 2 4 2007

31. Dete filed (Month, Day, Year)

821

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:00 p **Bertha White** May 9, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Gilchrist Center for Hospice Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 JF Marvland Feb 17, 1929 Director 218-22-3768 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar miner. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore N/A Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21206 4902 Truesdale Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ N/O Black Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Camille White Albert White 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4902 Truesdale Avenue Baltimore, Maryland 21206 Keith White Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Borrial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, Md. 05/16/07 King Memorial Park 4 Donation 5 Other (Specify). 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Deat 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform med? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charle Street Bulto. Md 2,20x 6701 BMC 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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			1 - State Registrar		•	rtificate of			eg. No. 0 U	7 15888	
	Physici	an	Decedent's Name (First, Middle, Last)     Month							3. Time of Death Year	
	/Media	al	Gloria A. Wied			4h Cibi Tours	Ma			007 9:16 P M	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Howard County General				r Location of Death .umbia	1	4c. County o	ward	
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)		Birthplace (State or Foreign Country)	
	Director		210-24-1199	<sup>™ 2</sup> 78	Yrs.	Months Days	Hours Will.	July 3,	1928	Maryland	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumatic event. I'm Medical Eraminar must be notified at		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits	
		tor	Maryland Howar	d	Co1	umbia				1 ☐ Yes 2X No	
		by Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Country?	
	s 23a	erall	9757 Polished Sto		-116 12	210				S. A.  - American Indian.	
"	fter de r Item inerr	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	13.	Was Decedent of H If Yes, specify Cubi	an, Mexican, Puert	o Rican, etc.)		White, etc.	
036	ours a	1 by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:		Specify:	White	
21215-0036	"netu	letec	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor	king	16b. Kind of Bus	iness/Industry	
12	filed withir Hygiene. other then ent, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2		ish Admin			Chu	rch	
	be filed tal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last)	<del>-</del>				ne (First, Middle, i	Maiden Sumame	)	
ylar	should be ind Mental marked o	ToE	James Marousek				Mary				
Maryland	12 sho		19a. Informant's Name/Relationship (Ty			ng Address (Street					
	s 1 and 2 of Health Item 27 I		Donna Wiedorfer (D 20a. Method of Disposition			Polished partition (Name of matory or other place				nd 21046 City or Town, State	
Baltimore,	e = ± 5		1 Burial 2 ☐ Cremation 3 ☐ R 1 Donation 5 ☐ Other (Specify)	emovar nom State		matory or other plai y Redeeme	1	3/2007	Raltimo	re, Maryland	
alti	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service License	1 4.	22	2. Name and Addre	ss of Facility Sc	himunek 1	Funeral	Homes,	
8	89 5 8 9		Man		97	705 Belai	r Rd., B	altimore	, Maryla	nd 21236	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betwee Onset and Dea								
			Immediate Cause (Final disease or condition resulting in death)  A Meros Cleno (c Carcho varcular Disease)  Due to (or as a consequence of):								
			Arche Stenosii								
		Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b.  Due to (or as a consequence or):  Sud Stage / lenal // if each					(8120		17	
	ate be executed nysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a con-	sequence of):	, rene	W / * /				
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68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th		IF FEMALE:								
Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnance	/		23d. Date Mont	of delivery th Day Year	
P.O.	the de	iyslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	or death 5L	Other (specify) _					
	res that igned by be deta	Completed by	y Ph	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tol	pacco use contrib	oute to the cause of death?
Records,	w require been sig should b		1[						Yes 2 No 3 Probably 4 Dinknown		
ecc	lawr nas be e 2 sh							24a. Was a autops	v pri	ere autopsy findings available for to completion of cause of	
<u>e</u>	i: The								2 No 1	eath? □Yes 2□No	
Vital	sicier s certif lirecto	o Be	25. Was case referred to medical examiner?	lospital:	2 ☐ ER/Outpatier	nt 3 DOA Ott	or	th (Check only on		(Specific)	
οl	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2	Certification: To	27. Manner of Death	28a. Date of Injury (Month, Day Year	28c. Injury at Work?  M 1 Yes 2 No		Adme 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
sior			1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be								
Division of	or Atl		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fam building, etc. (Specify)			reet, factory, office					
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, deatl	h occurred at the ti	me, date and place	, and due to the ca	ause(s) and man	ner as stated.	
	n 24 h n 24 h he Fur pletely	Medical	(Check only 2 Medicel Exemination)	ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	ppinion, death occu	rred at the time, d	ate and place, an	id due to the cause(s)	
	within To t	Σ	29b. Signature and title of certifier	644.		29c. Licens		2	9d. Date signed	(Month, Day, Year)	
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5	)		30. Name and address of person who co Mumer Cabapathi 2	1 100 V	Item 23a) (Type,	Meck R	000 /30	More	Mary 1	20 2007 land 2/22/	
Ĭ	* Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Si		d .			-		
	Registr	ar	MAY 2 4 2007	Done, a B	S AND AND						

DHMH 17 Rev 1/2001

07-03841

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Deborah Jean Wathen 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Da May 20, 2007 Year 1628 hrs Debra Jeanne Wathen Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 219 86 3610 M 2 X F 1960 Country) Feb 24. Director MD Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State s 23a or 28a-f show a notified at once. Yes 2 No Maryland Prince George Clinton hours after death with the Maryland Director 10g, Citizen of What Country 10e. Street and Number 10f. Zip Code 9646 Gwynndale Drive 20735 United States 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12, Was Decedent Ever in U.S. 11 Marital Status or items White, etc. Armed Forces? 1 X Never Married 2 Yes Divorced If Yes, Give Yaar 1 Yes 2XX No specify: Specify: White Widowed 27 is marked other than "natural", matic event, the Medical Examiner ģ or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 b Department of Health and Mental Hygiene. Baltimore, MD 21215-0036 12 Manager Verizon Bus 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roderick L. Wathen Be Alvera Casamento 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) item 27 is Ronald L. Dillon (Companion) 9646 Gwynndale Drive, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) May 24 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Important: 1 injury or oth Clinton, MD Resurrection Cemetery Other Specify Donation 5 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funer Service Ligensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Acute Coronary Thrombosis Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED X AMENDED #1.DE attending physician or use as the burial perME. 2867. Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) certificate has been signed by the attrector, page 2 should be detached for 1 Yes 2 No 9 🗸 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ج</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes Yes 2 After this certific funeral director, p 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medica Be Other4 examiner? Hospital: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 V Natural Pending Yes 2 No To the Funeral Director: completely filled in by the f Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 21, 2007 O.C.M.E

State

Registra

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Zabiullah Ali, M.D.

30. Name and address of person who completed carse of the ath (Item 23a)

Assistant Medical Examiner

**ORIĞINAL** 

111 Penn Street, Baltimore, MD 21201

amend 29th least Pype 8967 rin 24/97 ack Hidelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend 9 per F.H. g869 7/12/07Certificate of Death 2. Date of Death 3. Time of Death Month Day **Physician** 20 07:09 a<sup>M</sup> April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson 8. Date of Birth 30/07 9. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 Hours Months Min. 220-77-3613 Usual Residence of Decedent Director 1ary land 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐Yes **2** No MD Director 10e. Street and Number 10g. Citizen of What Country? items 23a or 2 iner must be n Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Black, White, etc. 1x Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed within Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Important: If Item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be ဂ္ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2/085 19a. Informant's Name/Relationship (Type. Print) Hiscilla U 20c. Mocation - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages ' Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 days a Bilateral pneumonia /Medical Due to (or as a consequence of): Examiner 7 days b Methacillin resistance staph aureus infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by prematurity, status post jejunal resection for 1 Yes 2 No 3 Probably 4 Unknown spontaneous perforation 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? 1K Yes 2 ☐ No 25. Was case referred to medical Certification: To Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 X Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea...
ral Director: Aftr 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/20/07 D38352 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 N Charles Street, Baltimore MD 21204 Schwartz, M.D. R. Beth 31. Date filed (Month, Day, Year) MAY 0 3 Registrar's Signature State 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Month Year **Physician** 05.05AM BEOFICE WILLIAM Elaine 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 Days Hours 0576 219 50 0576 Usual Residence of Decedent Director Mary / pus 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits at 1 Nes 2 No r 28a-f sh notified BALHNEUR Director Mary lake death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 1 INUIEW 2/2/5 5531 U513 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 25 If Yes, Give Year or Dates: 1 Never Married 2 Married 2540 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Food WILL Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) INDUSTRICO - 9 rade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHARP EdWARD Mc GE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trauonce. Daughter AUG 3108 -ACINDA ALDWELL 151 DE BALTIMORE 1 Ano 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHA IM Mr - IV mm, Finesh 21. Signature of Funeral Service Line see 5240 RENTERS burn KUMO BALANCE AL 2/2/1 arri 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months ancs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No certificate has autopsy 2 No 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 💢 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Director: After 5 Pending investigation 1 X Natural Injury To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolling Road, ste 108, catonsville, Mb 21228 576 N. Jyohn ari 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** ам Jessie Pearl Abbott 4. 2007 May 9:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. 25, 1919 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ **x**F 252-24-0916 87 Cataula, GA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☑ Yes 2 ☐ No Director MD Prince Georges Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #156 1207 Addison Road 20743 U.S.A. Funeral 14. Race - American Indian, "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Completed by 3 X Widowed 4 ☐ Divorced Black permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Dozier Evelyn Greene ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1805 Wiltburger St.N.W.Wash.D.C.20001 Jean Carter Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem May 11,07 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 20011 Hunt Fun. Home 908 Kennedy St. NW Wash.DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema **Physician** /Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Severe Aortic Stenosis the burial-tran Due to (or as a consequence of): physician IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease Stage 4 1 ☐ Yes 2 ☐ No 3 ☐ Probably X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No page 2 certificate 1∏ Yes Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ∐XNo ို 1 K Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation Injury 1 X Natural 124 hours after death.

16 Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 5/4/07 D4465688

7 Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

31. Date filed (Month, Day, Year) MAY 0 9 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year **BRENDA** BURRELL MAY 11:30p /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 229-74-0317 1 □ M 2 X F Hours Director 54 July 3, 1952 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Directo MD 1 ☐Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Arrington Dr. Funeral 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banker 2yrs. Bank of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Hicks Jr. Hettie Callaham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trat James M. Burrell/Husband 815 Arrington Dr. Silver Spring, MD. 20901 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John Baptist
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-11-2007 Forest, VA. 22. Name and Address of Facility
Marshall's Funeral Home, 21. Signature of Funeral Service Licenses 4217 9th st. N.W. Washington, D.C. 20011 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shirts, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METARTARIS ANCER WITH **Physician** /Medical Due to (or as a consequence of) Examiner AMASMIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PULMONARY METASTARIS WITH EFFUSION The law requires that the death certificate be executed and Due to (or as a consequence of). attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknowr þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à BNG 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → 2 ER/Outpatient 3 DOA P 1 Inpatient this 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Directory filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON ADVENTIST HOSP, TANONIA PARK (M) . 32. Registrar's Signatu 31. Date filed (Month, MAY 10 Registra

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

		For State Registrar	State of Marylar	-	artment of F r <i>tificate of</i>			glene Reg. No. 2 1 1 7	16894
Physic /Medi		Decedent's Name (First, Middle, Last)     OLIVER SYLV	ESTER	BRO	WN		2. Date of Dea Month APRIL 29	Day Year	3. Time of Death 12:20P M
Examination Funeral Director	ner	4a. Facility Name (If not institution, give st SOUTHERN MARYLAND H  5. Social Security Number 6. Sex 155-44-0423		. last birthday) Yrs.	4b. City, Town, of CLINTON  If Under 1 Year  Months Days	r Location of Death  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day	4c. County of Deat PRINCE GE 9. Bird (28, 1949 UN	
70		Usual Residence of Decedent   10a. State   10b. County   MD   PRINCE GEO   10e. Street and Number   10b. Street and Num	10c. C	ity, Town or Lo				10g. Citizen of What Co	10d. Inside City Limits 1 🛣 Yes 2 🗆 No
DEMILITION 1998: INTERTY INTO A 1.2.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	805 LARCHMONT AVEN	UE  2. Was Decedent Ever in Use Armed Forces?  1 Yes 2X No If Yes, Give		20743	lispanic Origin? (Sp an, Mexican, Puerto Specify:		U.S.A.  14. Race - Ame Black, Whit	rican Indian,
within 72 hours af ene. than "natural", or the Medical Exami	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ: (Specify only highest grade  Elementary/Secondary (0-12)  UNKNOWN	Year or Dates:	16a. Dece	dent's Usual Occup	oation during most of work d)	ing	16b. Kind of Business/	Industry
land A	To Be Co	17. Father's Name (First, Middle, Last) UNKNOWN					e (First, Middle,	Maiden Surname)	
y, INTALY and 2 shou saith and M n 27 is mai		19a. Informant's Name/Relationship (Typ KARYN T. LYNCH/PR.		19b. Mailir 805 L	ng Address <i>(Street</i> ARCHMONT	and Number or Rui AVENUE C	al Route Numbe	er, City or Town, State, 2 HEIGHTS, MD	Zip Code) 20743
DallIMOTE, ermit. Pages 1 a Department of He mportant: If Item iny injury or othe	1 8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State RIV	cemetery, crei /ERDAL	esition (Name of matory or other pla CREMATORY	5-4-	2007	20c. Location - City or RIVERDALE,	
permit Depar Impor any in		21. Signature of Funeral Service Licensed	all	7		OVER RD L	ANDOVER,	FUNERAL H MD 20785	OME Approximate
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	nyo ca	-dil	In fa	rut)	Interval Between Onset and Death
lav requires that the death certificate be executed tax requires that the death certificate be executed as teen signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical E	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	ivery Day Year
he lav requires that has reen signed by ge 2 should be deta	5	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to ∕es 2 □ No 3 □ Pr	o the cause of death?
he tav	e Completed	25. Was case referred to medical				00 Plant 4 Part	1□ Yes	rmed? prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of 2 No
Attending Physical Corrections of the function	Certification: To Be	examiner?	28a. Date of Injury (Month, Day Year)  28e. Place of injury - At I building, etc. (Spec	ER/Outpatier 28b. Time o Injury	f 28c. Inju Wo M 1	4 LI Nursing Ho	ome 5 ☐ Resid 28d. Describe h	lence 6 □Other (Spenow Injury occurred	
To the Hospital or within 24 hours afte To the Funeral Dir	Medical Ce	29a. Certifier (Check only one)  Certifying Physical Examination	iclan: To the best of my kr er: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	and due to the orred at the time,	cause(s) and manner as date and place, and du	s stated. e to the cause(s)
To th within	Me	29b. Signature and title of certifier  30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type.	Print)	1055		29d. Date signed (Mani	h, Day, Year)
St Regist	ate rar	ERIC McDONAII 31. Date filed (Month, Day, Year) NAY 1 0 2007	DMD 750	3 Sup	RALLS	RD Cli	inton	mol 20	735

Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** D. Burnett 2007 05 1505 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury If Under 1 Year If Under 24 Hrs. Hours Min. Hospice at the WICOMICO 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 ☑ M 2 □ F Months Days 544-34-0732 74 Yrs. Director March 10. 1933 Oregon Usual Residence of Decedent should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland \_\_\_Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be r 110 Parsonage Street 21826 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 2 **X** No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physici<sub>st</sub> Federal Government other t. Pages 1 and 2 should be filt, thent of Health and Mental Hy ant: if item 27 is marked other try or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Burnett 2 Mildred Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Glenn Burnett/Son 110 Parsonage Street, Fruitland, MD 21826 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page: Department o Important: If i any injury or 1 ☐ Burial 2 X Cremation May 14, 3 ☐Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 5 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician arkinson disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2D No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA Unpatient Medical Certification: To After this 27. Manner eath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending 1 TYes 2 □ No death. 2 ☐ Accident investigation the f 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, within 24 hours after death the Hospital completely 2 3

> State Registrar

(Check only one)

29h Signature and title of certific

31. Date filed (Month, Day,

MAY

Year)

10

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Cassol 32. Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

PO BOX 1733

29d. Date signed (Month, Day, Year)

Solisbu MD 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State 200 DH10 and TH	State of Maryla		artment of F rtificate of I				16896	
			= State RegistrarAMEND#19apenFHF 1. Decedent's Name (First, Middle, Last,		) Cei	lilicate of t	Dealli	2. Date of Death	g. No.C. U U 1	3. Time of Death	
	Physici	_		Banks				May 6,	Day Year 2007	8:30 P M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deatl		4c. County of Dear		
		ž.	Sunrise Assisted	Silver Spring Montgor							
	Funeral		5. Social Security Number 6. Sec	7. Age (In yr	rs. last birthday)  O. /. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, \	Year) 9. Bird	thplace (State or Foreign ountry)	
S. 18	Director		579-14-7596 Usual Residence of Decedent		94 Yrs.			June 14,	1912 Clev	reland, Tenn	
	/land low at		10a. State 10b. County	10c. (	City, Town or Lo	cation	-			10d. Inside City Limits	
	A-f sh iffed	ctor	MD Montgome	rv	Silver	Spring				1K∏Yes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	ountry?	
	ath w	rall	11621 New Hampshi			209			U.S.A		
	er de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ★ No	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit		
36	ırs aft Il", or xamlı	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No	Specify:		Specify: B1	ack	
5-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	10	l 6b. Kind of Business	Industry	
21218	thin 7 e. an "r	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	dunng most or wor d)	Kirig			
2	be filed within 72 hours after death with the Maryland tital Hyglene.  do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		12		C1e	rk	40. Mathada Nad	no (films beindels be	Fed Gov't		
-	0 = 0 =	Be	17. Father's Name (First, Middle, Last)  James Hunter					ne (First, Middle, Mi	aiden Surname)		
Ž	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other any Injury or other traumatic event, thouse.	To	19a. Informant's Name/Relationship (Ty	ve. Print)	19b. Mailir	na Address (Street		n Dunlap	City or Town, State, I	Zip Code)	
Maryland	nd 2 salth ar 27 is r trau			-daughter		-			Spring, MI		
ē,	s 1 a		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of matory or other place	ce)		Oc. Location - City or		
altimore,	Page Timent of the page of the		1 ☐ Burial 2 <b>图</b> Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	temoval from State			4	9. 2007 B	eltsville eral Serv	, MD	
ä	eparti eparti nporta ny Inj		21. Signature of Funeral Service Licens	ee							
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	eath. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death	
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1			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						
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60,	icate be executed physician and s the burial-transit	E E	resulting at death, east	Due to (or as a cons	equence or):						
58760,		edical		1							
Box	leath certific attending p I for use as I		IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome pf preg					23d. Date of de	livery	
	death atter	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		⊒Ectopic pregnancy ⊒Other <i>(specify)</i>	/		Month	Day Year	
0.	The law requires that the death certif ite has been signed by the attending tage 2 should be detached for use a	Physician/M	9 Unknown	9□Unknown							
S, T	es tha	ру Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						tobacco use contribute to the cause of death?		
Vital Records,	w require been significant		Dementia					1 ☐ Yes	3 2 No 3 P	robably 4x Unknown	
Sec.	has by	Completed				<del></del>		24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
<u>a</u>	slcian: The certificate harector, page							perform 1⊡ Yes 2g	ed? death? ☑No 1☐Yes	2 □ No	
<b>=</b>	slciar certif recto	Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	ot 3ELDOA Oth	or:	ath (Check only one			
Division or	ding Phys h. After this o funeral din	Certification: To	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe hov	nce 6 Other (Spe v injury occurred	ecity)	
	ath. ir: Aft		1 ⊠ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No								
N S	I or Attend after death   Director: / f in by the f	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (Stree	eet and Number or R State)	ural Route Number,	
	oltal o										
	e Hospital 124 hours a e Funeral D letely filled i	Medical	29a. Certifier 1X Certifying Phy (Check only one)  1X Certifying Phy 2 Medical Exami	sician: To the best of my k iner: On the basis of exami	knowledge, deat ination and/or in	h occurred at the till vestigation, in my o	me, date and place ppinion, death occ	e, and due to the cau urred at the time, da	use(s) and manner as te and place, and du	s stated. e to the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death. Completely filled in by the funeral director; p	Mec	29b. Signature and title of certifier	and manner stated.	1/1	29c. Licens	e number	. / 29	d. Date signed (Moni	th, Day, Year)	
	- S - Ö		1 Kaleur	TA	IM	My MO	2520	Y M.	ay 7, 2007	,	
	7		30. Name and address of person who co	· ·						20010	
			Robert T. Dibble	- <del>-</del> 1		St., N.W.	, North	Tower, Su	ite 4200 V		
63	Sta	te	31. Date filed (Month, Day, Year)	32. Rajistrar's Sig	gnature						

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 05 PM ac9 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Park Anne Hrund Balsam 20 Sevena Date of Birth (Month, Day, Ye) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Ohio 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M 2 🛛 F 66 1940 Director 276-36-0710 Oct. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Severna Park 1 ☐ Yes 2 No Anne Arundel Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21146 100 Balsam Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Community College (1-4or 5+) Elementary/Secondary (0-12) College - Science Dept. Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname)
Loretta Closterman 17. Father's Name (First, Middle, Last) To Be Robert Phillip Sommer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Balsam Drive Severna Park, MD 21146 Thomas E. Byrne/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 10, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD Veterans Cemetery 2007 4 Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Gov. Ritchie Hwy. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pancreance uncer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 KNo 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ Vo 24a. Was an autopsy performed? Yes 2010 page 2 1☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Mag 9 W Best 200 Rd Sule 300

D0064379

		1 - State Registrar			rtificate of		R	eg. No. 111	16898
Physici /Medic		Decedent's Name (First, Middle, Las     James Conrad Bi					2. Date of Deat Month May 0	Day Yea <b>8 2007</b>	3. Time of Death 2:30p M
Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of De	ath
		1280 Shallmar Roa  5. Social Security Number 6. Se		In yrs. last birthday)	Kitz If Under 1 Year	miller  If Under 24 Hrs.	9 Data of Righ	Garre	
Funeral Director			M 2□F	74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 2		irthplace (State or Foreig Country)  MD
Mot H		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
a-f st	ctor	MD Garret	t	Kitzm	iller				Yes 2□No
ms 23a or 28a-f show	Funeral Director	10e. Street and Number Race Street			10f. Zip Code	1538	1	0g. Citizen of What 0 USA	Country?
or Ite	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 11 Yes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13.1	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White
one. then "neturel", ne Medical Ext	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de co <i>mpleted)</i> College (1-4or 5+)	16a. Decec (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of workin d)	ng .	16b. Kind of Busines	s/industry
ygien verth	Con	10		Disab	led Amer	ican Veter		N/A	
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
1 Men narke	은	George Elzie Brady				Melissa			
ealth and m 27 Is n		19a. Informant's Name/Relationship (T Doug Brady/son	ype, Print)	1280	Shallmar	and Number or Rural Road Kit			
point. Tagys I am a should be main. Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then any injury or other treumatic event, I be M. ODGS.		20a. Method of Disposition  1 ∠Burial 2 □ Cremation 3 □ I  1 4 □ Donation 5 □ Other (Specify,		20b. Place of Dispo cemetery, cren Nethken		1 .	2007	20c. Location - City of Elk Garde	
Department Department Importent: If any injury or once.		21. Signature of Funeral Service Licens	96			neral wHome ngton Road			
hysician and medical fransit as the purial-transit	dicai Examiner	23a. Part1. Enter the comes, or comp shock, or heart failures. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. Larry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ischemic Due to (or as a c	cardio consequence of): Clerotic consequence of):	myopath				Approximate Interval Batween Onset and Death  3 Wks  20 yr
e atter	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 ( 4□Pregnant at tin 9□Unknown	☐Fetal death 3☐	Ectopic pregnancy	<i>y</i>		23d. Date of d Month	elivery Day Year
ig.	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in the ur	nderlying cause giv	ven in Part I.			to the cause of death?  Probably 4 Unknown
ate h	Completed						24a. Was an autopsy perform	prior to ned? death? No 1 \( \text{Ye}	autopsy findings available completion of cause of is 2 \sum No
After th funeral	ation; To Be	27. Manner of Death  125 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y		28c. Injur Wor	4   Nursing Hom	e 5 Reside	nce 6 XOther (Sp w injury occurred	ecity Repidera
within 24 hours after deart To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, office	28	8f. Location (Str City or Town,	eet and Number or F , State)	Rural Route Number,
y fill	Medicai	Zea. Certifier	sician: To the best of a ner: On the basis of ex and manner stated	amination and/or inv	occurred at the tir restigation, in my d	ne, date and place, ar pinion, death occurred	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	as stated. re to the cause(s)
in 24 he Fu pletel	100	29b. Signature and title of certifier	1011		29c. Licens		29	d. Date signed (Mor	nth, Day, Year)
within 24 hours after To the Funerel Discompletely filled in	2	) Inald K	Krhter &	X	D300	35	0	5-08-200	7

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 327AM Nicholas 2007 Q /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns HOOKINS Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 52 Yrs. Birthplace (State or Foreign Country) **Funeral** 217-62-1013 1 3M 2 ☐ F Director May 20 1954 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Director MD Carroll 1XXYes 2 □ No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 77 Marhill Ct 21157 USA · death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>م</u> Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Roofing Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic and injury or other traumatic and energy. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Francis Brazil Antoinette Marie Pace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Brazil/wife 77 Marhill Ct Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place). Bel. Air Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/10/2007 Bel Air, MD 21. Signature of uneral Service Licensee Prittend Funeration Home and Chapel, P.A. al 412 Washington Road Westminster, MD 21157 23a, part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 12hours /Medical Examiner Phoumonic Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physiclan and s the burial-transit be executed <u>Cirrhosis</u> Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9☐Unknown 9 Unknown þ signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 25 No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has t le 2 s autopsy page perform certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 0 this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending After Injury 1 Natural 5 Pending within 24 hours arten were To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the WJL 10

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Army De Zo ( ) 31. Date filed (Month, Day, Year)

MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

600 North WOLFE STREET

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

7. Age (In yrs. last birthday)

86

10c. City, Town or Location

Westminster

4b. City, Town, or Location of Death

Westminster

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

Days

21157

10f. Zip Code

Month

06

8. Date of Birth (Month, Day, Year) Feb 07 1921

May

3. Time of Death

ам

1:05

Birthplace (State or Foreign
Country)

10d. Inside City Limits

1¥1Yes 2 □ No

2007

Carroll

4c. County of Death

10g. Citizen of What Country? **USA** 

	D. C.
	Physician
(Free	/Medical
	Examiner
5	

Karolyn G. Bair

10b. County

40 S. Colonial Avenue

5. Social Security Number

10a. State

MD 10e. Street and Number

Director

213-50-6166

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

Carroll Hospice Dove House

Carroll

Funeral Director

death with the Maryland rms 23a or 28a-f show r must be notified at

ءَ	3√√Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			No- 14. Race - Am Black, Wh Specify:						
poloto	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	de completed)	(Give kind of work done life. DO NOT use retire	during most of working ad)		s/Industry of Maryland					
å	17. Father's Name (First, Middle, Last)	4	Registered	18. Mother's Name (First, Midd	lle, Maiden Surname)						
F	19a. Informant's Name/Relationship (7	Type. Print)									
	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	nemoval nom state	ace of Disposition (Name of emetery, crematory or other pla	05/08/2007	20c. Location - City o						
ouce.			22 Name and Addre	Fuheral Home	and Chape	1, P.A.					
_	Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.				Approximate Interval Between Onset and Death					
er	Sequentially list conditions	b. Right S	ence of):	veardail my	Gentin	4 ch					
xamine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Conjust	5.5000.5	t Failure		If cal					
	Due to (or a consequence of):										
vsician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 ☐ Fetal	death 3 Ectopic pregnance	у	23d. Date of do Month	elivery Day Year					
2		ontributing to death but not resul	lting in the underlying cause giv			to the cause of death?					
Complete				aut	topsy prior to	autopsy findings available completion of cause of					
Be	25. Was case referred to medical examiner?	Hospital:	Ott			spice !!					
	107 14 70 18	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju Wol	ry at 28d. Describe	sidence 6 Other (Sp. e how injury occurred	ecity) Fa E 1 /1 Ty					
Certifica	3 Suicide 6 Could not be 4 Homicide determined	20e. Place of injury - At nor	me, farm, street, factory, office	28f. Location City or To	(Street and Number or Fown, State)	Rural Route Number,					
edical (	29a. Certifier 1 ✓ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my know niner: On the basis of examinati and manner stated.	vledge, death occurred at the ti ion and/or investigation, in my	ime, date and place, and due to th opinion, death occurred at the time	ne cause(s) and manner a e, date and place, and du	as stated. ue to the cause(s)					
2	29b. Signature and title of certifier	edellation po	29c. Licens	se number	. 29d. Date algned Mon	oth, Day, Year)					
	John in mill	leton m.D.	688 ROG/0	Rd. Weston	unster M	10 2M57					
	0.0 1/258	32. Régigrar's Signath	the Sports	· · · J	<i>D</i>						
1/2001			ORIGINAL								
	Medical Certification: To Be Completed by Physician/Medical Examiner	15. Decedent's English State   15. Decedent   15. Decedent   15. Decedent   15. Decedent	15. Decedent's Education   (Specify only highest grade completed)   Elementary/Secondary (0-12)   College (1-4or 5+)	15. Decedent's Education   16a. Decedent's Usual Occur   16a. Decedent's Usual Occur   16b. Decedent's Part   16b. Decedent's Usual Occur   16b. Decedent's Name (First, Middle, Last)   17. Father's Name (First, Middle, Last)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   18b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street   19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street   19b.	Sequentially list conditions   15. Decedent's Education (Chine was first year)   16. Decedent's Usual Occupation (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was first which was many most of working (Chine was first which was first which was many most of working (Chine was first which was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working (Chine was first which was many most of working was many many many many many many many many	Specification   Specificatio					

8 State

Division or Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) MAY 9 2007

111 W. High

32. Registrar's Signature

104

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

SUITE

57.

EIKton

Registrar

D35653

MD

M. Hosford-Skapof, M.D.

2.8.0

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene

1- State Amend PI, line c, 25,27,28a-f, per ME Certificate of Death

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Carl Bruce Crew 5/3/2007 3:50pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 4/8/1947 Months 1X M 2□ F USA 220-74-4796 60 Director Usual Residence of Decedent 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 🏋 No MD Director Anne Arundel Gambrills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Medical Examiner must be n 948 Autumnwoods Rd. 21054 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 11. Marital Status Black, White, etc. 1 K Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Crew Lida Huggins ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnetta Cheatham Director 9180 Rumsey Rd. Suite D-2 Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥2 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 5/9/2007 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Intersec 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or \_\_ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examine Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last heumonia Due to (or as a consequence of): Examiner the death certificate be executed Choking on a food bolus with complications attending physician and for use as the burial-trar Due to (or as a consequence of): ADDROVED BY MEDICAL EXAMINER P.O. Box 68760. Physician/Medical IF FEMALE CERTIF 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the aid be detached to 1 Yes 2 No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performe 2 🗷 No or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 10 this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 🙀 No MAy 01, 2007 11:45 am 2 X Accident subject choked on a food bolus 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Adult Day Care Center 1254 Governor Ritchie Hwy, Arnold, MD To the Hospital 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KCI 0 31. Date filed (Month, Day, Year) 32. Reastrar's Signature State MAY 0 8 2007 Registrar

		í	For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylan		artment of rtificate o			Reg. No.	7   690   <sub>1</sub>		
ų0	Physici	an	Joseph	ine	Ci	imino		May 5,	Day Ye			
	/Medio		4a. Facility Name (If not institution, give si				n, or Location of		4c. County of D			
83		Ŭ.	ATRIA ASSISTED LIV	ING		SALIS	BURY		WICOMICO			
	Funeral Director		5. Social Security Number 6. Sex 099-14-6229	7. Age (In yrs. 93	last birthday) Yrs.	If Under 1 Ye Months Day		4 Hrs. 8. Date of Birt. (Month, Day 4/12/1	De	Birthplace (State or Foreign Country) Ierto Rico		
	yland 10W		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits		
	B-fsh	ğΝ	Maryland Wicomico	)	Nant:	icoke				1 ☐ Yes 2 🙀 No		
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?		
	ath w	rai	20341 Nanticoke				1840		USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other traumatic event, the Micdical Examinational to notified at ance.	by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U Armed Forces? 1	1	Was Decedent of If Yes, specify C 1 ☐ Yes 2 <b>X</b> N		in? (Specify Yes or No- Puerto Rican, etc.)	Black, V	omerican Indian, White, etc. White		
21215-0036	thin 72 ho e. an "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. I	DO NOT use ret	ne during most ( ired)	of working	16b. Kind of Busine			
2	led wi		9	-	Н	omemake	1	(= , , , , , , , , , , , , , , , , , , ,	Domesti	.c		
Maryland	ould be fil Mental H larked ott	To Be	17. Father's Name (First, Middle, Last)  Manuel Linares				Pat	's Name (First, Middle, uline Serra	ino			
, Mar	and 2 sh Balth and n 27 ie m		19a. Informant's Name/Relationship (Type Pauline Petrulli/C	laughter	2034	l Nanti	coke Dr	or Rural Route Numbe , Nanticok	e, MD 218	40		
Baltimore,	f of H		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo semetery, cren	sition (Name of matory or other p	olace)	Date	20c. Location - City			
Ħ Ħ	it. Partmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		The second secon	emetery		5/8/07	Nanticok			
Ba	Depa Impo any ii		21. Signature of Pulleral Service License	in CFS	ρ	iolloway 501 Snow	Funera Hill F	al Home Pro Rd., Salisb	fessional urv, MD 2	Association		
25.0	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one time disease or condition resulting in death)  Sequentially list conditions, tary, teaching to him to diataccuse. Enter Underlying Cause (Disease or injury)	Due to (or as a conseq	MOMIC uence of):	<b>\</b>	dying, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death		
68760,	tificate be executed g physician and as the burial-transit	ledicai Examiner	resulting in death) Last	Due to (or as a conseq	uence of):							
P.O. Box	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregna Other (specify,			23d. Date of Month	delivery Day Year		
rds, P	quires that en signed b uld be deta		Part II. Other significant conditions cont	ributing to death but not res	-		Δ			e to the cause of death?  Probably 4 Unknown		
al Reco	The larate has	Completed	Druent	161				24a. Was autop perfor 1 Yes	rmed? prior	e autopsy findings available to completion of cause of h? Yes 2 DNo		
Division of Vital Records,	Attending Physician: The death. sctor: Atter this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1  Yes  No  Ho  27. Manner of Death 1  Natural  5  Pending investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	f 28c. Ir				Specify ASSIYCA		
Divis	To the Hospitei or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office	се	28f. Location (S City or Tox		r Rural Route Number,		
	he Hoepitei or n 24 hours afte he Funerel Dir pletely filled in I	Medical (	29a. Certifier 11 Certifying Physical Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the vestigation, in m	e time, date and ny opinion, death	place, and due to the on occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)		
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	111		1000	ense number		29d. Date signed (M	Ionth, Day, Year)		
}	20									-		
	11/14	li li	30. Name and address of person who core was a company of the core was a company of the core was a company of the core was a core was	npleted cause of death (Item dva 186° M	n 23a) (Type, 1 1 1 1 V z	Print) AST S	ou B	501711	sny mi	21804		
7	Sta Registr	ite ar	31. Date filed (Month, Pay, Year) 9 20	32. Tegistrar's Signa	ture	mel						

07-03599 John Kelly Curtis

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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		1- For State Certificate	of Death	Reg. No	).	
Physicia		Decedent's Name (First, Middle,Last)		Date of Death     Month Day	3. Time of Death	
ledical Examin	er	JOHN KELLY CURTIS		May 10, 2007	1906185	
e - fo		4a. Facility Name (if not institution, give street and number) 409 Zelma Avenue	4b. City, Town, or Location of Death Capitol Heights		lc. County of Death Prince George's	
Funeral	7	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	s. 8. Date of Birth(MN	//DD/YYYY) 9. Birthplace (State or	
Director	L	· <u>A</u> 05	Yrs. Months Days Hours Mir	JIILY 30,	Foreign Washington,	
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits	
<b>≱</b> .7	ı	Maryland Prince Georges Capitol Ho			1 XYes 2 No	
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Director	10e. Street and Number 409 ZELMA AVENUE	10f. Zip Code 20743	1	itizen of What Country? TED STATES	
ath with items 23s	Funeral	1 Never Married 2 v Married Armed Forces?	Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.	
after der ral", or i	by Fu	3 Widowed 4 Divorced If Yes, Give Year of Dates:	Yes 2 No specify:	Lich	Specify: Black	
0036 within 72 hours after iene. rer than "natural", Medical Examiner			dent's Usual Occupation (Give kind of g most of working life. DO NOT use re		. Kind of Business/Industry	
15-0036 filed within 72 Hygiene. d other than "	Completed		ician		Private	
5-00 led with Hygiene other i	틹	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	n Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	B	JOHN KELLY CURTIS, Sr.	Anna	Dyson		
221 hould I nd Mer is mar	의		iling Address (Street and Number or			
e, MD I and 2 sho Health and item 27 is			MADISON STREET,			
			position (Name of cemetery, r other place)		c. Location - City or Town, State	
Page nent c		4 Donation 5 Other Specify: Metropo.		7 18,200 A	lexander, VA.	
Baltimore, permit. Pages I an Department of He Important: If ite	Ī	21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Alexander S. Pop 5538 MariboroPik	e, P.A	11 11 007/7	
	_	23a. Parl I. Enter the disease, or complications that caused the death. Do not ent				
Physician /Medical		failure. List only one cause on each line.			Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardio  Due to (or as a consequence of):	vascular disease			
-	ļ	Sequentially list conditions, b.				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and transit		d				
e exec	Physician/Medical	X UNPENDED  AMENDED  #23a, 27, perME, g867,	5/20/07 TT			
760, ficate be exe g physician a	Me	IF FEMALE: 1 250. II yes, outcome or pregnancy			23d. Date of delivery	
30x 68 death certifi e attending for use as	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	nancy	Month Day Year	
Box 68 death certif	ysic	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)			
O. B. nat the d at the d by the etached		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to the cause of death?	
, P.(	d b			1 Yes 2	No 3 Probably 4 ✔ Unknown	
Division of Vital Records, rate or Attending Physician: The law requir rs after death.  "I Director: After this certificate has been sited in by the funeral director, page 2 should the contraction of the	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
e law	Ē			performed 1 ✓ Yes 2		
tal Rectinn: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Chec			
Vita ysicia his cer direct	Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat	tient 3 DOA Other Nurs	ing Home 5 Resi	idence 6 Other: Scene	
ding Ph	1: To	27. Manner of Death 28a. Date of Injury 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how	injury occurred	
lon leath.	tio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
VÌSİ or Att fter d	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (Stree or Town, State)	et and Number or Rural Route Number, City	
Dipital of ours at filled i	Certification:	4 Homicide determined (Specify)		1		
Hos Fur Fur	Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inves	ccurred at the time, date and place, an tigation, in my opinion, death occurred	nd due to the cause(s) I at the time, date and	and manner as stated. place, and due to the cause(s)	
To the within To the comple	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)	
		Mh. his all the	O.C.M.E.	М	lay 11, 2007	
Λ		30. Name and address of person who completed cause of death (Item 23a)				
			1 Penn Street, Baltimore, MI	D 21201		
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature	,			
Regist		MAY 1 8 2007 Figure D. Popular				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY 8, **Physician** MARY RITA 2007 10:10 A M DI PRIMA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21752 OSCAR HAYDEN ROAD BUSHWOOD ST. MARY'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🛛 F 034-14-1174 Yrs Director 81 JUNE 26, 1925 MASSACHUSETTS Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1763 RED OAK LANE 20601 UNITED STATES Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify ۾ 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH NICOLOSI 2 CARMELINA MODULO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHIL DI PRIMA - SON 1763 RED OAK LANE, WALDORF, MARYLAND 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MD VETERANS CEMETERY 14, 2007 CHELTENHAM, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility HUNTT FUNERAL HOME M00053 3035 OLD WASHINGTON RD., WALDORF, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (Ur as a consequence of, Examine burial-tran Due to (or as a consequence of): physician Physician/Medical the attending | as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □ tonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 1□ Yes 2 🖼 No 2 No Be 25. Was case referred to medical 26. Place of Death Check onl one Ż ပ

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. or Attending Physician: No the responsibility of the funeral Director: After this To the Funeral Director: After this result in by the funeral of the Certification:

examiner?			
1 Yes 2 146	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☑ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
00 0 00 4 1 0 00 00			

29a. Certifier (Check only one)	1 ☐ Certifying Physician: To the best of my knowledge, death occ 2 ☐ Medical Examiner. On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and due to tr gation, in my opinion, death occurred at the tim	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month. Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRMALADEVI JAYANTHAN, MD, 3328 OLD WASHINGTON RD., WALDORF, MD 20603

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 1 0

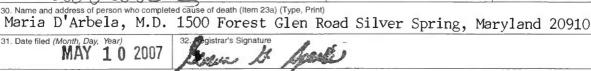
Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 200<sup>3</sup> Sharon Elizabeth 8:47 A.M Dorak /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 63 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Year June 1, 1943 6 Sev 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2X F Ohio 420-54-9929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show deral Examiner must be notified at Maryland Prince George's Beltsville 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 4618 Quimby Avenue United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event; the Medagonce. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Willard Gramblev Margaret Devlin Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Joseph Dorak -husband 4618 Quimby Avenue Beltsville, Maryland 20705 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 9 Metropolitan Crematory 5/8/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home,
4400 Powder MIII Road Beltsville, Wor Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Blood Loss Anemia /Medical Due to (or as a consequence of): Examiner Acute Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed the attending physician and the dor use as the bunal-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Ischemic Colitis 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【XNo 24a. Was an has autopsy page 2 performed' certificate 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🖎 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 1 0 2007



D62520

May 6, 2007

			1- State of Maryland / Departr	ment of He icate of D			ene	17 16908
		191	Decedent's Name (First, Middle, Last)			2. Date of Deat	1	3. Time of Death
	Physici /Medi		Stella v DiFrancesco			Month May	Day 7. 200	Year 7 5:40 P M
	Examir			. City, Town, or t	ocation of Death		4c. County	
			Sligo Creek Nursing Home	Takoma				ontgomery
	. Funeral Director		577-20-8119 1 M 2 SF 86 Yrs. MC	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 16,	<sup>Year)</sup> 1920	9. Birthplace (State or Foreign Country) Washington, DC
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on				10d. Inside City Limits
	Mary f sho	ro	Maryland Prince George's	Hyatts	i 110			1 ☐ Yes 2 ☐ No
	r 28a	Director	<u> </u>	Of. Zip Code	VIIIE	10	g. Citizen of W	/hat Country?
	h with		5805 42nd Avenue, Apt. 222	207	81		USA	
5-0036	be filed within 72 hours after death with the Maryland ital hygiene. A other than "natural", or items 23s or 28s-f show event, it is Modical Examination must be notified.	by Funeral	Armed Forces? If Yes 1 □ Never Married 2 □ Married 1 □ Yes 2 🖫 No	Decedent of His s, specify Cuban Yes 2 X No	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Black	e - American Indian, k, White, etc. White
20	"natur	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupat of work done du	ion iring most of working	ng 1	6b. Kind of Bu	siness/Industry
2121	filed withir Hygiene. other than ent, Ille M.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)  3 Laundr	NOT use retired)			Laur	ndry Service
	e filed al Hygie other vent, II	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, M	laiden Sumame	в)
<u>a</u>	should be and Mental amarked o	ToE	Guiseppe Roncagliolo		Amel	lia Arra	tta	
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationship (Type, Print) -Brother 19b. Mailing Ad	ddress (Street ar	d Number or Rural	Route Number,	City or Town, S	State, Zip Code)
	and lealth m 27 her tr				ace, Hyat		-	
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any in ury or other traumatic evonce.		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cremator  Fort Lincol	ry or other place;	May	14,		City or Town, State
a	permit. Departrimports any init		21. Signature of Funeral Service Licensee 22. Nat	me and Address	of Facility Collins I			od, Maryland
m	205 20		James & Cally 500	Univers	ity Blvd.	W. Si	lver Sr	
THE PERSON NAMED IN	Physician /Medical Examiner		23a. Part1. Exter the disease, or complications that caused the death. Do not enter the shock, onheart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  aAcute_Leuker_ia  Due to (or as a consequence of):	e mode of dying,	such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.  b. Myocardial Infarcti Due to (or as a consequence of):	on				
	ficate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			····		
60,	be ex ician burial	al E	Due to (or as a consequence of):					
09/89	ficate phys s the	edical	d					
O. BOX	at the death certiff by the attending itached for use as	Physiclan/Mo		opic pregnancy ner (specify)			23d. Date Mon	e of delivery oth Day Year
ecords, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underly	lying cause given	in Part I.			ibute to the cause of death?  3 □ Probably 4 □Unknown
E.	The law ate has b	Completed				24a. Was an autopsy perform	ed? de	eath?  Yes 2 No
VItal	Physician: The this certificate I ral director, page	Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one	)	
0	Physi this c	2		DOA Other	4 Develoring Hom			
	D 0 0	atlon:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury	28c, Injury a Work? И 1 □ Ye	s 2 □No	8d. Describe how	v injury occurre	,d
DIVISION	ne Hospital or Attendin n 24 hours after death. te Funeral Director: Aft eletely filled in by the fur	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fi building, etc. (Specify)	factory, office	21	Bf. Location (Stre City or Town,		or or Rural Route Number,
	he Hospit n 24 hours he Suners	Medical (	29a. Certifier (Check only one)  1  Certifying Physicien: To the best of my knowledge, death occi 2  Medicel Exeminer: On the basis of examination and/or investig and manner stated.	urred at the time gation, in my opin	, date and place, ar nion, death occurre	nd due to the cau d at the time, dat	use(s) and man e and place, ar	iner as stated. nd due to the cause(s)
	To the within 2 To the complet	Œ	29b. Signature and title of certifier  Stun Tu	29c. License r	9998	29	d. Date signed May 8,	(Month, Day, Year) 2007
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Tee. M.D. 3415 Hamilton Stree		Hyattsvil	lle, MD	20782	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Relistrar's Signature					
	- nogioti		MAY 1 0 2007 Mayor H for					

			1 - For Stata Registrar	State of Ma	arylaı	nd / Depa		nt of H	ealth a		_	-	0 7	6	909
H	Physic	ian	Decedent's Name (First, Middle, La	_							Date of Death     Month	Day	Year		e of Death
1	/Medi Examir	cal	4a. Fecility Name (Whot institution, given University of MD)	ne street and number) Medical Cer				Town, or	Location of	Death	05 -	4c. County	of Death	10:	39 FM
	Funeral Director			Sex 7. Age		last birthday) 71 Yrs.	If Unde Months	n 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth Month, Day July 28	°°°1935	9. Birthi Mary	lace (Stai http://and	te or Foreign
	yland now		10a. State 10b. County		10c. C	ity, Town or Lo	cation								e City Limits
	e Mar 3a-f st	ctor	Maryland Talbot		E	aston								1 <del>∐</del> Y	fes 2 ☐ No
	23a or 24	Funeral Director	7080 Lauren Lane,	#507			10f. Zip	2160:	1				Citizen of What Country? Inited States		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Madical Exercite minist be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				/as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 X No Specify:			Bla	14. Race - American Indian, Black, White, etc.  Specify: White			
5-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced (Give life.	dent's Usu	al Occupa	ition	of worki	00	6b. Kind of B	usiness/ln	dustry	
121	within ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Admini						Federa	1 Cor	70 <b>1810</b> 111	ont.
d 2	filed with Hygiane other tha		17. Father's Name (First, Middle, Last	)		Admiti	istia	rive			(First, Middle, M			eriii	ent
Maryland	should be ind Mental is marked o	To Be	Harry  19a. Informant's Name/Relationship			Lowe	• • • • • • • • • • • • • • • • • • • •	(2)	Flora	a 		Mar	shal!		
<b>≅</b>	nd 2 shoulth and 27 is m.		Norma J. Thacker	, ,							d Route Number. 3 Beltsv				20705
Je,	of Health Item 27		20a. Method of Disposition			Place of Dispo	sition (Na	ne of	a)	С	ate 2	Oc. Location -			
Ë	nit. Pages partment of cortant: If I		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		Ce	dar Hil	l1 Ce	metei	y   5	5/12	/2007 S	vitlan	d, Ma	ryla	nd
Baltimore,	permit. Pages Department of Humbortant: If Ite any injury or of once.		21. Signature of Funeral Service Licensee Bond Property Bond Bond Bond Bond Bond Bond Bond Bond							Funeral ad Belts	Home, ville,	PA Mary	·land	20705	
	Physician /Medical Examiner  portion and price	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	consec	v Epno quence of):			, such as c	ardiac o	respiratory arres	н,		Approxim Interval E Onset an	Between
O. Box 68760,	death certificate e attending phy d for use as the	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Wo 9  Unknown	Due to (or as a d. 23c. If yes, outcome of 1 Diversion at the 19 Unknown	of pregna	ancy	Ectopic pr					23d. Dai Mo	te of delive	ry Day	Year
ds, P.O.	es tha	þ	Part II. Other significant conditions of	ontributing to death bu	t not res	sulting in the ur	nderlying c	ause give	n in Part I.		23e. Did toba				
Sor	w requir been sl should	etec									1 🗆 Yes				Unknown
		Completed									24a. Was an autopsy performe	r	Vere autor prior to con death?	npletion of	gs available cause of
Ē	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Minpatien	1 2 🗆	ER/Outpatient	t 3□ DC	Othe	-		(Check only one) ne 5 ☐ Residen	- 6 CO		,	
on of	ing After une		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	,	28b. Time of Injury		8c. Injury Work		2	8d. Describe how			,	
÷	br At ftar c	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur building, etc.	y - At h (Specif	ome, farm, stre	eet, factory				8f. Location (Stre City or Town,		er or Aura	Route Nu	umber,
	To the Hospital or At within 24 hours eftar or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 KCertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of a and manner state	enimaxa	owledge, death tion and/or inv	occurred estigation,	at the time in my opi	e, date and nion, death	place, a occurre	nd due to the cau od at the time, date	se(s) and ma	nner as st and due to	ated. the cause	∍(s)
	Som to the state of the state o	Σ	29b. Signature and title of certifier	1				. License			290	. Date signed	(Month, I	lay, Year)	)
	12		yeast h	lecas				185	68		0.5	108	/200	7	
			30. Name and address of person who	450M 22	5	GRUG	Print)	TREC	TI	BAI	Timons,	MD.	212	01	
	Sta Registr	te ar	31. Date filed (Month, Pay, Year)	2007 32. Resistrar	s Signa	ture	COAS.	,			,				

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completely

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) MAY 0 8 2007



MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Soly Are Annagelis Mel 2141

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 8870 8-23-07 yt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#23a.Prt.1.PerPhys.PGC5-11-07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 **Physician** 12:30PM BONG GΙ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 73 1**X** M 2□ F Director 128 32 14,1933 KOREA JUNE Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at MONTGOMERY ROCKVILLE MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.

The filem 27 is marked other than "natural", or items 23a or items and re other than the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be no. USA 20852 **WAY #4** 12205 ACADEMY by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2XXMarried Specify ASIAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DRIVING SCHOOL PROPRIETOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YOON EUN NAM J00 KIM HEE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 12205 ACADEMY WAY #4 ROCKVILLE EUN /SON JONG JIN 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/11/07 SILVER SPRING MD GATE OF HEAVEN Funer 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 21. Signatus 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Brain Death resulting in death) /Medicai Due to (or as a consequence of) Intracranial Hemmorrhage Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after det To the Funeral Directo completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 000 65 12 s of person who completed cause of death (Item 23a) (Type, Print) RD BETHESDA MD 20814 AMIRALI NADER MD 8600 OLD GEORGETOWN 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State MAY 1 0 2007 Reģistrar

12,30

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Benjamin L. Evans May 4, 2007 9:17A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FutureCare-Pineview Nursing Home Prince Georges Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | March 29, 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Kansas **Funeral** 1**⊠**M 2□F 72 488-36-8863 Yrs. Director Usual Residence of Decedent ehow. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f ehor Director 1 XYes 2 No Md. Clinton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9106 Pineview Lane 20735 United States by Funerai item 27 is marked other than "natural, or Items other traumatic event, the Medical Examiner ms 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the following and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer 5+ Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Vercie Dorsey Evans Sr. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12524 Woodstock Drive Fast
Upper Marlboro, Md. 20772 Pamela Rowles/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: I eny injury o Veterans Cem. 5/10/07 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sanature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. B910 Silver Hill Rd., Suitland, Md. 20746 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Impediate Cause (Finat disease or condition resulting in death) Physician /Medical Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) inding physicien and use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death ed by the e 5 Other (specify) O 9 Unknown 9 Unknown ۵. ate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. <u>6</u> PERITONITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Division of Vital 1 Yes 2 XNo 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending Atthin 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky, M.D., 12070 Old Line Centre #207, Waldorf, Md. 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 9 2007 Registrar

		Registrar			Ce	rtificate	of L	Death			Reg. No.	. 0 0 7	1001
<b>Physici</b>	an	1. Decedent's Name (First, Middle, I	,							2. Date of De Month May 5	Davis	7 Year	3. Time of Deat
/Medic		Margaret Ann E		or)		4h City	Town or	Location of	of Death	May 3		County of Death	9:00 A
LAGITIE	iei	Genesis Elderca		•			ldor	_	Ji Dodiii			Charles	
uneral		Social Security Number 6		Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 04-16-	th Year)	9. Birth	place (State or Fore
irector		578-14-3385 Usual Residence of Decedent	1□M 2\\F	88	Yrs.		Julys	1100.5		04-16-	1919	Virg	ginia
Mo W		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Lim
1 2	tor	Maryland Charl	es	Whi	ite Pl	ains							1 X Yes 2 □
in ream and represent 1 years of them 23s or 28s-f show them 27s or 28s-f show other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Cou	intry?
23a	rai	4225 Southwinds	Place, Ap	. 106		20	695				U.S	S.A.	
Item Der m	une	11. Marital Status	12. Was Deceder Armed Force:	\$?	6. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or Ni If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					o- 14. Race - American Indian, Black, White, etc.		
o. ii.	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			1 ☐ Yes 2	X No	Specify:			3	Specify: W	hite
atura Cal E	ted	15. Decedent's	Education		16a. Dece	dent's Usua	Occupa	tion			16b. Kind	d of Business/li	ndustry
Med	pje	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4o	r 5+)	(Give life.	kind of world DO NOT use	( done du e retired)	uring mosi	t of work	ing			,
1 2	Sol		01	,	Accou	nting					U.S.	Gover	nment
o po o ven	Be	17. Father's Name (First, Middle, La.	•							e (First, Middle,	Maiden S	umame)	
ie marked other traumatic event, III	<sup>L</sup>	Samuel G. Presgr								• Furr			
7 io n traun	1	19a. Informant's Name/Relationship	7, 7, 7							al Route Numbe			
Item 27 other tra	1	Ricky Evans - So  20a. Method of Disposition	n	20b. Pla	1082 ace of Dispo	/ Aly	ssa e of	Lane		ldorf,		and 206	
, <del>= =</del>		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		0	ace of Dispo metery, crer			- 1					
mportant: any injury o	i	4 Donation 5 Other (Specify) Fort Lincoln Cemetery 05/09/2007 Brentwood, Maryla 21. Signature of Eugenral Specific Linesee 22. Name and Address of Facility 4739 Baltimore										Maryland	
E : 8		Caluttel)	lay		1000				,	P.A.			e, MD 20
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caus	ed the death.							•		Approximate
sician		Immediate Cause (Final disease or condition	athe	100000	1 - 1-	Car	100	304	0.	deal	11.		Interval Between Onset and Death
edical		resulting in death)	a. Due to (or a	s a conseque	ence of):	0,00	ew v		Carl .	Colona	<i>/</i> 3/C		
miner		Sequentially list conditions.	b	Mio	·								
- i	ine	if any, leading to immediate	Due to (or a	s a conseque	ance of):								
death certificate be executed e attending physician and of for use as the burial-transit ilclan/Medical Examiner		Cause (Disease or injury	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	s a conseque									
sician and burial-trans	аі Ехап	that initiated events	c. Due to (or a	s a conseque									
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ending physician and use as the burial-trans	ın/Medicai Exan	that initiated events	d	e of pregnan	ence of):						23	d. Date of deliv	ery
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 8:10A John Hollmann Flieger 2007 May 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Casa Assisted Living Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

New York 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□F 058-18-7404 Director 1/15/1916 91 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 723 Sonne Drive 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1936–56 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Major U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Flieger Emily Hollmann ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 Sonne Drive, Annapolis, Maryland 21401 John H. Flieger/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 5-7-07 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify Assisted 1 Yes 2 No Hospital: 1 Inpatient L<sub>o</sub> 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica To the Hospital within 24 hours a To the Funeral I

10\*

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician 7:30p™ William R. Forlifer 2007 May 5, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15, 1926 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 216-20-6718 80 May Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Arnold 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21012 USA 505 Broadwater Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Engineer Aerospace 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Reifsnider William Henry Forlifer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arnold, MD 21012 505 Broadwater Road Health tem 27 Ethel E. Forlifer/Wife Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 May 8, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conservence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disp to for an a gangaguence of Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown ate has been signed by page 2 should be detac Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 TYes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 5 Pending investigation after death.

Director: After in by the further. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

MAY 0 8 2007

			For State Registrar	State o	of Marylan		artment of F		Mental Hygi	iene	17	16916	)
177		7	Decedent's Name (First, Midd)	le, Last)					2. Date of Deat	'n		3. Time of Death	_
Ш	Physici		Alice Geasey	Fisher					Month May	Day 19 2	Year 2007	5:55 P M	
1	/Medic		4a. Facility Name (If not institution		mber)		4b. City, Town, o	r Location of Death		4c. County			_
	LAGIIII	101	Frederick Mem	orial Host	oital		Fre	derick		Frede	erick		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vanel	9. Birthpla	ace (State or Foreign	1
	Director		215-20-9839	1 ☐ M 2 🏋 F	81	Yrs.	Months Days	Hours Min.	3/18/2		Count	M D	
-	D		Usual Residence of Decedent										
	irylar ihow	_	10a. State 10b. County	'	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits	
	e Ma Sa-f s	cto	MD Fred	erick		Fre	derick					1 ☐ Yes 2 🛛 No	
	or 28	Director	10e. Street and Number				10f. Zip Code		10	Og. Citizen of W	/hat Count	ry?	
	23a ust b	a l	6808 Mountai	ndale Ro	ad		2170			USA			
	ems erm	Funeral	11. Marital Status	12. Was Dec	edent Ever in U orces?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America k, White, e		
36	Juithin 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fi	1 Never Married 2 Mai	If Vas G	2[XNo ive		1 ☐ Yes 2 🌠 No	Specify:		Specify	Whi	t- 0	
8	ural"	d b	3 Widowed 4 □ Divorced		Dates:	10. P	d		7.	16b. Kind of Bu			
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Maryland 21215-0036	nd 2 should be f lith and Mental H 27 is marked of r traumatic eve	2	19a. Informant's Name/Relation		11-	19b. Mailir	na Address (Street		May Ri		State. Zio	Code)	_
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	The Head		20a. Method of Disposition	ons ba		Place of Dispo	sition (Name of matory or other pla	rndare	Rd Thur Date	10 O D E 20c. Location -			_
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0.		ا ا	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	juence of):							
18	rted Insit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b>									
%- %-	be executed sician and burial-transit	Examine	resulting in death) Last	CDue to	(or as a conseq	uence of):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical		d									
9	ificate by physical p	edic						77					
Вох	eath certific attending p for use as 1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregn		7			23d. Dat	e of delive	у	
m.	death a atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	4□Preg	birth 2□Feta nant at time of c		∃Ectopic pregnanc ∃ Other <i>(sp</i> ec <i>ify)</i> _	У		Mo	nth	Day Year	
0	that the de	hys	9 ☐ Unknown	9□Unkr	nown								
٦, ص	res tha igned b	by P	Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contr	ibute to the	e cause of death?	
ğ	w require been sig should b	p p	Coronary	ortery	Dise	ase			1 <b>2</b> Ye	es 2□No	3 Proba	abiy 4 □Unknown	
00	aw re s bee	Completed		•					24a. Was a		Vere autop	sy findings available	,
æ	The lav	Į į							autops	ned2 c	leath?	npletion of cause of 2□ No	
ta		Ö	25. Was case referred to medic	al				26. Place of Dea	1  Yes 2 ath (Check only on			2   IVO	_
Division or Vital Records,	Physician: this certific	0 0	examiner? 1 ∐ Yes 2 ☑ No	Hospital	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	oor:	lome 5 ☐ Reside		er (Specify	)	_
Ö			27. Manner of Death	28a. Date	of Injury	28b. Time o			28d. Describe ho			/	_
ion	or Attending I ther death. Director: After in by the funer	igi	1 Natural 5 Pendi 2 Accident invest	ng (N/o/ igation	nth, Day Year)	Injury		Yes 2 No					
Vis.	Attencr death	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 200. Flat	e of injury - At h	ome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Numb	er or Rurai	Route Number,	
	al or s afte al Dir	Certification:	4 I Horniolde	Dunc	ing, etc. (Opeca	· <i>y</i> /			Only of Your	i, Siale)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the	e best of my kno	owledge, deal	h occurred at the t	ime, date and place	e, and due to the co	ause(s) and ma	nner as st	ated.	_
	he Hi in 24 he Fu pletel	Medical	one)	I Examiner: On the and ma	nner stated.	adon and/or Ir	ivesugation, in my	opinion, death occi	uneu at the time, d	ale and place,	anu due to	uie cause(s)	
	To t. To th	Ž	29b. Signature and title of certifi	er		n	29c. Licens			9d. Date signed			
			+auzi '	Kizvi.	MO 1	My		6 218		May 1	4,2	2007	
	10		30. Name and address of person	n who completed cau		n 23a) (Type,	Print)	1 01	ef, Fr	ada "	- L	-	
_	10		Fauzi Ki	QM, IVS		00 M	lest 1+	n Stre	et, rr	eauri			
		ate	31. Date filed (Month, Day, Year AAY 2 4	2007	Registrar's Sign	ature	Sil.						
	Regist	rar	MINI A 4	Loui A Sala	-	- 0							

Division of vital Records, P.O. Box 68/60,	Baltimore, Maryland 21215-0036
Lor Attending Physician: The law requires that the death certificate be executed	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Director: After this certificate has been signed by the attending physician and	Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show
in by the funeral director, page 2 should be detached for use as the burial-transit	

Funeral Director

ian			e (First, Middle,	,							2. Date of D			V	3. Time of Deal	
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ner .		a. Facility Name (If WASHINGTO					-		Location o			4c	. County	of Death	TGOMERY	
	5	. Social Security N 579-30-48	352	6. Sex 12∑M 2□F	7. Age (In yrs. 77		Months		If Under 2 Hours		8. Date of Bi (Month, D JULY	irth lay, Year) L7, 1	929	9. Birth Cou WASI	nplace (State or Foi Intry) HINGTON,	
	-	Jsual Residence of 0a. State	10b. County		10c. Cit	ty, Town or	Location								10d. Inside City Li	
Director	-	MARYLAND	MONTGO	OMERY	SIL	VER S	SPRING								1X∏Yes 2□	
Dire		0e. Street and Nun					10f. Zip					10g. Cit	Og. Citizen of What Country?			
eral	-	805 LOMBA	ARDY COL	3	cedent Ever in U	10 1							J.S.A.			
by Funeral		<ol> <li>Marital Status</li> <li>Never Marri</li> <li>Widowed</li> </ol>	_	Armed F			If Yes, spe		n, Mexican	, Puerto F	Rican, etc.)	0-		ck, White	e - American Indian, k, White, etc. : WHITE	
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ខ	-	7 F.O. A. N	(F' - 1 84° 1.00 - 1		5+		PI		ICIST SMITHSONIAN INSTITUT							
Be c	100	7. Father's Name ( ABRAHAM (		•					18. Mother's Name (First, Middle, Maiden Surname) CELIA SOTSKY							
٩	1					19b. Ma	ilina Address					her City	or Town	State 7	in Code)	
Ш	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  805 LOMBARDY COURT, SILVER SPRING, MARYI															
To Be Completed by Funeral Director	20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   4 Donation 5 Other (Specify)   5 Other (Spec															
	2	21. Signature of Funeral Service Licensee  22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 2085.														
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death															
II. I	8	Seguentially list cor	nditions	Due to	o (or as a conseq	uence of):	CELL	CANC	ER							
al Examiner	CO	Sequentially list cortain, leading to impause. Enter Under Zause (Disease or intainitiated events esulting in death) L	rlying injury	b. MAS	o (or as a conseq	uence of): CITES quence of): VAL IN										
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 9:34 AM na 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 20 F 91 Yrs. 577-07-9838 Director 1915 Wash. D. C. June Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other then "nature!", or Itema 23a or 28a-f ahow vent, the Medical Expiritive must be nutified at 1 X Yes 2 No Be Completed by Funeral Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 Montrose Road 20852 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any fijury or other traumatic avent, the Medical Exercises once. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Postal Service Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Gantz မ Lena Sherling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Frank Gantz - Brother 15300 Pine Orchard Dr., # 3F, Silver Spring, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/10/2007 Mount Lebanon Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death, so not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) +ITZHEI **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physicien IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Day Year 5 Other (specify) 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Diractor: After filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cumpletely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSE

State Registrar MD

07-03317 Cynthia Denise H	lort	Please Type or Print in Black Indelible Ink. Ensure All Copton  State of Maryland / Department of Health and Mental		gible.
		1- For State Certificate of Death		eg. No. 3. Time of Death
Physicia Medical Examir		Cynthia Denise Horton	Month May 1, 20	Day Year 0700 hrs
r <sup>2</sup>		4a. Facility Name (if not institution, give street and number)  Martin Luther King Jr Hwy & Rt 50  Glenarden	eath	4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours 7. Age (In yrs. last birthday)	Hrs. 8. Date of Bir Min. 1/20	/ 58 Solution SC
ия		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
/land -f show s	tor	MD PG Bowie	1	1 X Yes 2 No
the Mar	Director	10e. Street and Number 10f. Zip Code 20721		USA
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married    12. Was Decedent Ever in U.S.   Armed Forces?   1 Yes 2 No    13. Was Decedent of Hispanic Origin?   If Yes, specify Quban, Mexican, Pue		14. Race - American Indian, Black, White, etc.  Specify: Black
ours afte	d by	or Dates:		16b. Kind of Business/Industry
336 thin 72 h ne. than "n ledical E	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  B.A. Degree  Driver	Tellioo)	Private
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Cor		ame (First, Middle, Seller:	
212 thould be and Ments is mark		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number	or Rural Route Nur	mber, City or Town, State, Zip Code)
e, MD I and 2 sho Health and item 27 is		Everett Horton - Husband 15105 Joppa Pl.,  20a. Method of Disposition  1 X Rurial 2 Commettion 3 Removal from State crematory or other place)	Date Date	20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		Glenwood Cemetery 5		Washington, DC
Balt permit Depart Impor injury		Christe Bluford 3605 14TH St.,	NW, Was	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries	ac or respiratory an	rest, shock, or heart Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause		
ted J ansit	Examiner	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-	
3760, ficate be executed g physician and s the burial - transit	dical	UNPENDED AMENDED		
ox 68760, eath certificate be attending physici for use as the buri	ਕ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	egnancy	23d. Date of delivery  Month Day Year
O. Box at the death cdby the attented by the attented at the attented for us	Physici		23e. Did t	tobacco use contribute to the cause of death?
S, P.O. puires that the range of signed by a lid be detached.	ed by		1 Ye	es 2 No 3 Probably 4 Unknown  s an 24b. Were autopsy findings available
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the the second the Funeral Director: After this certificate has been signed by the attending physician and physician in the Funeral Director: After this certificate has been signed by the attending physician and physician in the funeral director, page 2 should be detached for use as the burial - transition of the content of the purial of the page 2 should be detached for use as the burial - transition of the content of the purial of the page 2 should be detached for use as the burial - transition of the purial of the pur	Completed		auto perfo 1 ✓ Yes	psy prior to completion of cause of death?
Vital hysician this cert	o Be	examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other 4   No	ursing Home 5	Residence 6 Other: Scene
ion of tending Pheath. or: After the funeral	tion: T		Driver auto	how injury occurred auto collision
Division pital or Attendi ours after death. reral Director: /	Certification:	Accident Investigation    Accident Investigation   Suicide   Could not be determined   Could not	or Town,	(Street and Number or Rural Route Number, City State) r King Jr Hwy & Rt 50, Glenarden, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:			, and due to the cau	use(s) and manner as stated.
To the within? To the comple	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
	,	O.C.M.E.		May 1, 2007
R (8)		30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201	
St Regist	ate trar			

Registrar DHMH 17 Rev 1/2001 OCME 2006

	3	- 61	1 - For State Registrar  1. Decedent's Name (First, Middle	State of	Maryland	/ Depa	artment of tificate of	<b>c. Ensure A</b> Health and I Death	Mental Hyg	Are Le liene G. No.	gible.	1692	
•	/Me	ician dical niner	JAMES  4a. Facility Name (If not institution	, give street and numb	Per)	HENDE		or Location of Death	2. Date of Dea Month MAY 2,	2007	Year	3. Time of Death 3:45P	
	Funer	al .	PRINCE GEORGE  5. Social Security Number		Age (In yrs. last	t birthday)	CHEVERL	Y		PRI	nty of Death	ORGE	
	Direct	or	240-76-1787  Usual Residence of Decedent  10a. State 10b. County	14 M 2 ☐ F	64	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) 03-10-1	943	9. Birthi NORT	place (State or Fore http://CAROLIN	
	r 28a-f eho	Director	, so sound	GEORGE	OXON	Wn or Loc	LL					10d. Inside City Limi	
	a 23a o	ralD	6249 OXON HILL	RD #304			10f. Zip Code 20745			g. Citizen o U	ntry?		
9036	s 1 and 2 should be filed within 72 hours alter death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23a or 28a-f ehow other treumatic event, the Medical Examiner must be notitied at	by Funeral	Narital Status     Never Married	12. Was Decede Armed Force ad 1 Yes 2 If Yes, Give Year or Date	<b>∑</b> No	13. W	as Decedent of H Yes, specify Cubi	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bl	ean Indian, etc.		
Maryland 21215-0036	within 72 h ene. then "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4c		Sa. Decede (Give k life. De	nt's Usual Occup nd of work done O NOT use retired	nation during most of worki	ng 1	6b. Kind of I	Business/Inc		
nd 2	al Hygie I other	Be Co	11th 17. Father's Name (First, Middle, L.	ast)		CC	NSTRUCT	ION 18. Mother's Name	(Fine Minister 16		VATE		
ryla	hould bid Ment	To	JOHN HENDERSON					EMMA HENI	ERSON				
	Health an tem 27 is in		19a. Informant's Name/Relationship (Type, Print) LENA HENDERSON/WIFE  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Number								ON HILL, MD 2074		
Baltimore,	permit. Peges 1 and 2 s Department of Health ar Important: If item 27 is any injury or other treu		1X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice	city)	cemet	LEASA	NT CEMET	ERY 05-12	2-2007 N	C. Location	, NC		
Ä	Per Imp		K.D. H.	-hall	1	747	4 LANDOV	s of Facility JB ER RD LAN	DOVER, M	D 2078	AL HOM 85	ΙĒ	
8760,	Physician /Medical Examiner superprise physicien and superprise physici	ı M	23a. Part1. Enter the disease, of control of the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate devents resulting in death) Last	b	line.  S a consequence s a consequence s a consequence	of):	UR.	j, such as cardiac of	respiratory arres		ĺ	Approximate Interval Between Onset and Death	
P.O. Box 6	t the death certif by the attending ached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death		opic pregnancy her (specify)			23d. Dat Mor	e of delivery	ay Year	
ords, F	w requires that been signed I should be det		art II. Other significant conditions	contributing to death b	out not resulting in	n the unde	lying cause given	in Part I.	23e. Did tobac		ibute to the	cause of death?	
æ	The ate h	Completed							24a. Was an autopsy performed 1 Yes 2	24b. W	/ere autopsy rior to compleath?	y findings available letion of cause of	
f Vii	d is	To Be	5. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2□ER/Ou	Instrumt S	DOA Other:	26. Place of Death (	Check only one)			3 NO	
ision	After	Certification:	7. Manner of Death  1. Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injur (Month, Day	y Year) 28b. T	ime of njury	28c. Injury a Work?	4 Nursing Home t 280 s 2 No	5 Residence  1. Describe how in	6 □Othe	r (Specify)		
Div	prisal or pours after erei Dira		4 Homicide determined	building, etc	. (Spacity)				Location (Street City or Town, St	110)			
	within 24 hours after death within 24 hours after death To the Funerei Director: completely filled in by the	edic	9a. Certifier (Check only one)  Certifying Pt 2 Medical Example 1  Db. Signature and title of certifier	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, examination and ted.	death occ	urred at the time, ation, in my opini	date and place, and ion, death occurred	due to the cause at the time, date a	(s) and man nd place, ar	ner as stated and due to the	d. e cause(s)	
,	(n)		Daniel a	lexander	- MO		29c. License no	815	.5	ate signed	27	, Year)	
	8		Name and address of person who DANIEL BIEKAN Date filed (Month, Day, Year)	DEK 3W	ath (Item 23a) (1 1 HOSP)	Type Print	DR C	HEVERLY	ms	2018	3		
	Stat Registra	_	MAY 0 9 2007	32. Registra	r's Signatura.	2		/					

Physicia /Medica Examine	n al er
Funeral Director	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	To Be Completed by Funeral Director
Physician /Medical Examiner	

		•	For State Registrar	Oldio or ini	ar y rair ar r	Certi	ficate o	f Death			Reg. No	.20	07	16	921
	Dhysiei		1. Decedent's Name (First, Middle, La.	st)					2	. Date of De Month	eath Da	ay	Year	3. Time o	f Death
	Physicia /Medic		Richard Daniel	Hayre						May_	-	007		6:45	a M
	Examin	er	4a. Facility Name (If not institutiоп, giv	e street and number)		4	b. City, Town	, or Location of I	Death		40	c. County of	of Death		
			Holy Cross Hospi 5. Social Security Number 6. S		e (In yrs. last i	hirthday)	Silve If Under 1 Year	r Sprin		. Date of Bi	rth	Mor	1tgor 9. Birthi	nery place (State	or Foreian
ľ	Funeral Director			M 2□F	78		Months Day		Min.	(Month, Da	ay, Year		Cou	ningto	
	iand ow It	ŀ	10a. State 10b. County		10c. City, To	own or Locat	tion							10d. Inside C	City Limits
	Mary I-f sh	ţċ	Maryland Montgo	morii.		C:1	er Spr	ina						1 ☐ Yes	2 No
	or 28s	Director	10e. Street and Number	mer y			10f. Zip Code	9			10g. C	itizen of W		ntry?	
	th wit	ral	906 Snure Road				209					USA			
	tems tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa	s Decedent of Hispanic Origin? (Specify Yes or N es, specify Cuban, Mexican, Puerto Rican, etc.)			No- 14. Race - Ameri Black, White,					
36	", or i	by F	1 ☐ Never Married 2 <b>KM</b> Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ I If Yes, Give Year or Dates:	∾ Kore	1 [	]Yes 2k∏ N	lo Specity:				Specify:	Wh:	ite	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	edt	15. Decedent's E	ducation		6a. Deceden	nt's Usual Occ	cupation		_	16b. l	Kind of Bu	siness/ir	ndustry	
215	within 72 iene. than "na he Media	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5+)	(Give kin life. DO	nd of work doi NOT use reti	ne during most o ired)	of working						
	filed withi Hygiene. other than	Con	12			Tel	ephone	Instal			<u> </u>			ne Com	pany
pu	be filed within 72 hours after death with the Marylar tital Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last Alfred Joseph Ha					18. Mother's	,				e)		
χ	12 should be filed w n and Mental Hygie is marked other ti raumatic event, th	2	19a. Informant's Name/Relationship (		1	9h Mailing /	Address (Str	eet and Number					Stato Zi	n Code)	-
Maryland	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		Margaret D. Hayre					ad, Sil						5 5000)	
ē,	s 1 ar f Hea ftem 2		20a. Method of Disposition				ion (Name of tory or other p		Dat	te	20c. L			own, State	
Ë	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special					Cemeter	У	ay 13		lver	Spr	ing Ma	ryland
Baltimore,	rmit. ppartn porta y inju		21. Signature of Funeral Service Lice	nsee	,	<sup>22</sup> F	lame and Add	dress of Facility	lins	Funer	cal	Home	Inc	•	
_	90 E # 9		dames 5	bole	7			versity				ver S	pri		
н			23a. Part1. Exter the disease, or comshock, of heart failure. List only	plications that caused one cause on each ii	The death. D	o not enter t	the mode of o	lying, such as c	ardiac or	respiratory a	arrest,			Approxima Interval Be Onset and	etween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. End-Stag		•	ease							Yea	rs
	Examiner			Due to (or as	a consequent	ce ot):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequence	ce of):									
	cuted nd ransit	Examiner	that initiated events	c Due to (or as a consequence of):											
30,	rificate be executed ng physician and as the burial-transit	I Ex	resulting in death) Last	Due to (or as	a consequen	ce of):									
68760,	cate b	Medical	•	d											
9 X	£ 5.00		IF FEMALE:	23c. If yes, outcome	pf pregnancy	,						23d. Dat	e of deliv	/erv	
Box	death cer e aftendin ed for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 4 □ Pregnant a	2 Fetal de	ath 3 □E	ctopic pregna Other <i>(specify,</i>					Mo		Day	Year
P.O.	that the de ned by the a detached f	Physician/	9 Unknown	9□Unknown											
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the unde	erlying cause	given in Part I.						the cause of	
Records,	w require been si should b									1	Yes			bably 4 <del>*</del>	
ec	law I	Completed								24a. Wa:	opsy	24b. V	Vere aut	opsy finding ompletion of	s available cause of
al F	cate has page 2;	Con								1□ Yes	formed?	lo 1	l ☐ Yes	2 □ No	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2XINo	Hospital:	0.E.E.	/Ot. = ti = et	SELDON (	Other:		Check only			- (0		
9		.: To	27. Manner of Death	28a. Date of Inju	ent 2 ER/	b. Time of	2 DOY	4 ⊔ Nurs njury at Vork?		e 5□Res 3d. Describe				іту)	
Division	Attending r death. ector: After	Certification:	1 Natural 5 □ Pending 2 □ Accident investigatio		y rear)	Injury		Yes 2 N	lo						
Vis.	l or Attendatter death	tific	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Place of III	jury - At home tc. (Specify)	, farm, stree	t, factory, offi	ce	28	If. Location City or To	(Street a	and Numb	er or Ru	ral Route Nu	mber,
Q	urs afte ral Dir lled in														
	e Hospita 24 hours e Funeral etely filled	Medical		hysician: To the best miner: On the basis of and manner st	of examination										e(s)
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	2			29c. Lice	ense number			29d. D	ate signed	d (Month	, Day, Year)	
	7.		· Mose	MD			D	32332			j	May 8	3, 20	007	
	204/		30. Name and address of person who Suresh K. Gupta,	completed cause of o	death (item 23 BO1 Geo	a) (Type, Pri	<sup>int)</sup> Avenue	, #220,	Sil	ver S	orin	g, MI	209	902	
	Sta	ate	31. Date filed (Month, Day, Year)	27-	rar's Signature	. 1	- At a								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** DEWEY ISREAL, Jr MAY 5 2007 9:59 A<sup>M</sup> /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8341 Shady Spring Drive Gaithersburg MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **¾**M 2 □ F Months 67 Dec.17,1939 Maryland Director 219-26**-**3939 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at Yes 2 No Gaithersburg MD Montgomery Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 20877 U.S.A. 8341 Shady Spring Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen E. Duffin Dewey Isreal, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Douglas Ave., Rockville, MD 20850 Doris Prather (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Buria 2 Cremation 3 Removal from State 5/12/07 Rockville, MD 20850 Lincoln Park Cem ation 5 Other (Specify) 21. Signatul 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. re of Funeral Sen 246 N.Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause Final Physician 4 months Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the g□ Unknown **q** □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Lung Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1□ Yes 2 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P. 24 hours after death. e Funeral Director: After t 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5-9-07 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Rd, #208, Rockville, MD 20850 Ravi Passi, M.D. State 2007

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) **Physician** Caroline Ervin Josey 2007 Рм May 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 104 River Drive Anne Arundel Annapolis 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year, 7. Age (In vrs. last birthdav) **Funeral** Days Hours 578-26-4679 1 M 2 T F 79 Director July 30, 1927 Washington, DC Usual Residence of Decedent 10c. City. Town or Location t be notified at 10d. Inside City Limits 10b. County Maryland Anne Arundel 1 ☐ Yes ♣️TNo Annapolis Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 104 River Drive 21403 r than "natural", or items 23a the Medical Examiner must b U.S.A. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ZONo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White δ 3√Vidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important; If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Ervin Adelaide Demuth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Josey/son 6 Sands Avenue Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Anne's Cemetery 5/12/2007 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses 10 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratos **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner dostouln Palony Disease Chronii Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of) Examiner the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🖼 6 detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this completely filled in by the funeral 28a. Date of Injury 28b. Time of after death. 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 26 373 Fo 8-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selowers ISI Rd. Dampoles, Unal 2182 31. Date filed (Month, Day, Year) **MAY 0 9** 2007 State Registrar

			1 - For State Registrar	ate of Maryland		tificate of I		na Ment		ne 1. No. 2 () ()	7	16924	
ī	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	en					ate of Death onth	Day O	ear T	3. Time of Death	
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	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Da	ate of Birth			e (State or Foreign land	
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980	72 hours after death with the Maryland 'natural', or liems 23a or 28a-f show dical Examiner must be notified at	by Funeral	1 Never Married 2 Married	Vas Decedent Ever in U.S. Armed Forces? □Yes ATXNo i Yes, Give ⁄ear or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes ※ No	lispanic Origii an, Mexican, Specify:	rigin? (Specify Yes or No- an, Puerto Rican, etc.) /:			14. Race - American Indian, Black, White, etc. Specify: White		
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lary	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	F	19a. Informant's Name/Relationship (Type. I							er, City or Town, State, Zip Code)			
			Betty A. Agovino Da  20a. Method of Disposition			sition (Name of natory or other place		Date Date	ark, DE 19711  20c. Location - City or To			, State	
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Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hardesty Funer 12 Ridgely Ave. Annapolis, MD									P.A.	
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	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contribu	uting to death but not result	ting in the ur	nderlying cause giv	ren in Part I.		23e. Did toba 1 □ Yes	acco use contribu		cause of death? ly 4	
or Vital Records,		Completed							24a. Was an autopsy performe	ed? prid	or to compl ath?	findings available letion of cause of No	
· Vit	Physician: The this certificate har all director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2  Hosp	ital: 1 □ Inpatient 2 □ E	:R/Outpatien	t 3 DOA Oth			eck only one) 5 Residen	) ice 6 □Other	(Specify)		
n or	ing Ph After th uneral		27. Manner of Death 1	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	ry at rk?	28d. i		v injury occurred	()		
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	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month May 18	B <sup>ay</sup> 2007	3. Time of Death			
	/Medic	al	Lasca Johnson	45 City Tayle and postion of Dooth		4c. County of Death	3.30			
	Examin	er	4a. Facility Name (If not institution, give street and number)  37 Green Ave.	4b. City, Town, or Location of Death  Aberdeen		Harford				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign			
	Director		216-24-3487 <sup>1□ M</sup> ADF 80 Yrs.	Months Days Hours Min.	8. Date of Birth 2/2/1927	Mary.	land			
	pun *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits			
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	r 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?			
	th with		37 Green Ave.	21001		U.S.A.				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal rust be notified at once.	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ ∀es 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: White	, etc.			
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į	To t withi To t	Σ	29b. Signature and title of certifier  Marky Was my	29c. License number		Mey 18	2007			
	20		30. Name and address of person who completed cause of death (Item 23a) (Typ  MARK WILA 2 North	e. Print) Avenue BEL	AIR M	ARYLI	WE 21014			
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 2 4 2007  33 Registrar's Signature	erit i						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** 09 2007 GLADYS VICTORIA KING 9:35A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST HOSPICE CARE CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 5, 1952 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 💢 F 54 Yrs. 217-62-6164 Director MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director MARYLAND HAVRE DE GRACE HARFORD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1230 BATTERY DRIVE 21078 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married 1 ☐ Yes 2X No Specify Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should re filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BANK OFFICE ADMINISTRATOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Men al h ANDREW HENSON MILDRED BOND 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health or Important; if Item 27 is any injury or other trau CHARLES KING / HUSBAND 1230 BATTERY DRIVE, HAVRE DE GRACE, MARYLAND 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/07 4 ☐ Donation 5 ☐ Other (Specify) JAMES UNITED CEM HAVRE DE GRACE, MD 22. Name and Address of Facility

LISA SCOTT FUNERAL HOME, P.A.

552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licensee MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ladder Immediate Cause (Final Lancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for Month Year in the past 12 months? 1 ☐ Yes 2 Do Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autonsy performed? Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) NULL FLU Hospital: Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending **∱** Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No death. 2 ☐ Accident filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) harles or Baronne 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring thoniks no 6701

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Division or Vital Records,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Howard Joseph Kapfer, Jr 100 200 /Medical county of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** -are ONSVI timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 12XM 2□ F Days Hours Min Director 215-10-2455 Jan 28 1916 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f shor must be notified at Director MD Baltimore Catonsville 1 ☐ Yes 2 TXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane 21228 USA Funeral item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Paradise Amoco Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Joseph Kapfer, Sr Hattie Angstadt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 707 Maiden Choice Lane Catonsville, MD Grace Kapfer/wife permit. Pages 1 and Department of Healt Important: if item 2 any injury or other? 05/09/2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens 21. Signature of Funeral Service License Printer Tunerad Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) y ears Physician soraHA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown peen s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 1∐ Yes 2 🗔 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 New Home 5 Residence 6 Other (Specify) 1 Tes 2 No ို 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss opperson who completed cause of death (Item 23a) (Type, Print) 30. Name and add Mald hoice Lane 31. Date filed (Month, Day, Year) State MAY 0 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 5021 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 7, 2007 2:45a M Suzanne D. King May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 86 Blossum Lane Elkton Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Days Months Min. Hours 215-78-9453 84 Director July 6,1922 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Ceci1 Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 86 Blossum Lane 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John B. DeLancey Mary Louise Carrithers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 states that a limportant; if item 27 is any injury or other trau Mary King/Daughter 1109 Echo Court North, Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10, Elkton Cemetery 2007 Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Superal Savice Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as car lac or respiratory arrest. MD shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung /Medical Due to (or as a lon) equence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ √es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy nerforme To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this continuation. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes ₽ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 54086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

15 hatri

2007

31. Date filed (Month, Day,

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32. Figistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	رک Sta		30. Name and address of person who in ICHAEL B. 1/31. Date filed (Month, Day, Year) 20	ILLON	r's Signature	pe, Print)	PR	WEST	307 7	Ou	500	21204	
F	within 2 To the	Med	29b. Signature and title of certifier	Bellel	lon in		29c. License	9110			signed (Month		
	4 hours Funeral	edical Co	29a Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on hiner: On the basis of and manner sta	examination and/	Sath seei or investig	urned at the tim gation, in my op	e data and place, sinion, death occur	and due to the ear	us.(s) a ate and p	and manner as place, and due	stated. to the cause(s)	
Division of Vita	after death.  Director: After this certificate ha in by the funeral director, page	$\vdash$	Avaminer?  1 Yes 2 Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 Security 1 Accident investigation 3 Suicide 4 Homicide Hospital: 1 Inpatient 2 ER/Outpatient 3 Security 1 Inpatient 2 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1 Inpatient 2 Inpatient 3 Security 1					4 Nursing Ho at ? ∕es 2 No	28d. Describe ho 28f. Location (St. City or Town	ow injury	occurred	ral Route Number,	
	s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 Î ♣ Ø o	Hospital:	at 2   SP/0.4-	ationt of	Othe		th Check only on	-		2.3	
Vital Records,	certificete has b	Completed	25 Was once stored to						24a. Was a autops perform	y ned? 2 <b>X</b> No	prior to death?	topsy findings available ompletion of cause of	
ords, P	eu g	<u>م</u>	Part II. Other significant conditions of	ontributing to death bu		ne underly	ying cause give	en in Part I.				the cause of death? obably 4 □Unknown	
	itie taw equites that the obstit certifications are been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome and the street of the	2 Fetal death		opic pregnancy er (specify)			23	3d. Date of deli Month	very Day Year	
	g physician and as the burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    CARDIO-PULMONARY AREST   Due to (or as a consequence of):										
	hysician /Medical		Immediate Cause (Final disease or condition			101	DARY	ARRE	ST			Onset and Death	
B B	Depa Impo		23a. Part1. Enter the disease, or com shock, or heart failure. List only	Tivel	the death. Do no	Harl	kins Fu	neral Ho			lta, PA	A 17314  Approximate Interval Between	
Baltimore,	<ol> <li>Pages 1 and 2 should riment of Health and Mer rtant: if item 27 is marks rjury or other traumatic</li> </ol>		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Specification)  21. Signature Funeral Service Lie	()	cemetery,	cremator LY'S	n (Name of ry or other plac Cemete me and Addres	ry 5/11			eation - City or esville		
			Laura K, Taylor/Daughter 4633 Graceton Road, Whiteford, MD 21160  20b. Place of Disposition (Name of Disposition (										
ıyla		2	Charles E. Sla		19h A	Mailing Ad	dress (Street		n Cochra		Tour State 2	(in Code)	
nd 2	Hygin other	Be Co	17. Father's Name (First, Middle, Last,		10	cgibi	CCICC N	18. Mother's Nam	ne (First, Middle,	Maiden S		Lare	
Maryland 21215-0036	al Hygiene. I other than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5	()	Give kind ife. DO N	s Usual Occupi of work done of NOT use retired tered N	during most of wor ()	king		od of Business/		
036	De liled within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or itema 23a or 28a-f show event, the Medical Examinar must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		_	Decedent of H s, specify Cuba Yes 2 XNo	ispanic Origin? (Sin, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)		4. Race - Ame Black, White Specify: W	ncan Indian, e, etc. nite	
	in with the 23s or 28	Funeral Director	10e. Street and Number 4625 Graceton Roa	d		10	0f. Zip Code 21160		1	-	en of What Co JSA	untry?	
;	e Maryla la-f sho	ctor	MD Harfor	d	White		on .					10d. Inside City Limits 1 ☐ Yes 2X No	
	Director		216-30-0002  Usual Residence of Decedent  10a. State 10b. County	□м 200 г	72 Y	S.			6/4/193	4	Mar	yland	
	Funeral		4625 Graceton R 5. Social Security Number 6. S	ex 7. Age	e (In yrs. last birth	Mo	White Under 1 Year Onths Days		8. Date of Birth (Month, Day 6/4/193	1	larford	hplace (State or Foreign untry)	
	/Medic Examin		4a. Facility Name (If not institution, giv			4b.		Location of Death		4c. (	County of Deat		
	Physici		PATRICIA S. KEL						2. Date of Dea Month May	Day	Year 2007	3. Time of Death  2:00 A	
	- · ·		1 = For State Registrar  1. Decedent's Name (First, Middle, La	State of Ma			icate of		A	leg. No.	400/	15930	

			For State Registrar	State of Maryland / Dep Ce	eartment of Health and leartificate of Death	, ,	ene g. No. 2007 16931				
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Howard E. Lo	ockard, Jr.		2. Date of Death Month May	Day Year 5 2007 03:30 AM				
	Examir	ier	4a. Facility Name (If not institution, give 402 Abbott Drive	street and number)	4b. City, Town, or Location of Death		4c. County of Death  Cecil				
ath m	Funeral Director		219-58-2092	x 7. Age (In yrs. last birthday Yrs. 53	Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 31,	year) 9. Birthplace (State or Foreign Country) 1953 Maryland				
	f show ed at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits 1  ☐ Yes <b>¾(X</b> )No				
	with the Nia or 28a-i	Funeral Director	Maryland Cecil  10e. Street and Number  98 Lockard Lane	North Ea	10f. Zip Code 21901		Og. Citizen of What Country?				
920	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by		12. Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:		nited States  14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	I within 72 ho jiene. r than "natur the Medical"	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Giv. College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) Ontractor	rking 1	6b. Kind of Business/Industry  Housing				
Maryland 2	ages 1 and 2 should be ent of Health and Mental nt: If item 27 is marked o y or other traumatic eve	To Be C	17. Father's Name (First, Middle, Last) Howard E. Lockard		18. Mother's Nar	ne (First, Middle, Maiden Surname)  Tester					
Mary		1 8	19a. Informant's Name/Relationship (Ty	16 P	- '		e Number, City or Town, State, Zip Code) n East, Maryland 21901				
Baltimore,			Rosalisa Hodgson / 20a. Method of Disposition  1XX Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Date 2	Oc. Location - City or Town, State Orth East, Maryland						
Balti	permit. F Departm Importar any inju		21. Sign wire Funery Service Life	ee 2	22. Name and Address of Facility C:	rouch Fund	eral Home h East, Maryland21901				
*	Physician /Medical	1000	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)		nter the mode of dying, such as cardian		Approximate Interval Between Onset and Death  Whitevol				
68760,	icate be executed physician and physician and sthe burial-transit	edical Examiner	Sequentially list conditions, it is a first to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):							
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rds, P.	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions col	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? s 2 □ No 3 ➡ Probably 4 □ Unknown				
al Records,		Completed				24a. Was an autopsy perform	prior to completion of cause of				
or Vital	<b>5</b> ∓ 18	n: To Be	27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  Injury	ent 3 DOA Other: 4 Nursing F	ath (Check only one) tome 5 Resider 28d. Describe how	nce 6 Bother (Specify) DAUGHTEN.				
Division	or Attendate death Director: in by the	Certification:	1 ★ Astural 5 Pending investigation 5 Could not be determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	pet and Number or Rural Route Number, State)				
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cau urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)				
D	To the within To the comp	Me	29b. Signature and title of certifier	auu	29c. License number		d. Date signed (Month, Day, Year)				
_	3		4701 Ogleton	ompleted cause of death (Item 23a) (Type In - Stanton R	d Suite 21	00 N	ewark be 19713				
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	erli						

			1 - For State of M	laryland / Dep <i>Ce</i>	partment of F		, ,	iene eg. No.	00	1 1 5 0 0	
ľ	- 79		Decedent's Name (First, Middle, Last)				2. Date of Deat	th Car		3. Time of Death	
	Physici Medic		Louis Michael McCart	er			May 7,	2007	Year	10:10A M	
ì	Examir		4a. Facility Name (If not institution, give street and number	)	4b. City, Town, o	r Location of Death		4c. County	of Death		
-			1414 McCarter Lane 5. Social Security Number   6. Sex   7. A	ge (In yrs. last birthda)	Mayo  If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne	e Arur		
H	Funeral Director		400.000	7 Yrs. last birthday	Months Days	Hours Min.	(Month, Day, 4/26/1	Year)	Count	ace (State or Foreign try) y land	
	p		Usual Residence of Decedent				4/20/1	750			
	arylar show	<u>_</u>	10a. State 10b. County	10c. City, Town or I	Location				10	od. Inside City Limits 1 ☐ Yes 2 ☑ No	
	the M 28a-f	Director	Maryland Anne Arundel  10e. Street and Number	Mayo	10f. Zip Code		11	On Citizon of I	What Count		
	3a or	<u>=</u>	4119 Shoreham Beach Rd.		2110	5	'	10g. Citizen of What Country? USA			
	death	Funeral	11 Marital Status 12 Was Deceden	Ever in U.S. 13	J. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	an Indian,			
9	or ite	/ Fu	Armed Forces  1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑  If Yes, Give	No	1 ☐ Yes 2 No	Specify:	Hican, etc.)		ck, White, e		
Ö	hours tural", al Exa	d by	3 Widowed 4 Divorced Year or Dates:	160 Doo				Specify.			
5	in 72 n "nat fedic	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occup re kind of work done o DO NOT use retired	during most of work d)	ing	16b. Kind of B	usiness/indi	ustry	
212	d with giene er tha	mo.	Elementary/Secondary (0-12) College (1-4or 2 years	o+)  Air Q	uality Comentalis	ntrol	- 1	Departi	ment o	of Defense	
pu	oe file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			ne)		
<u> </u>	12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To	Louis F. McCarter				eanne Br		- <u>-</u>		
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print) Thomas G. MCarter/ Brother	19b. Mai	ling Address (Street McCarter	Lane, Ed	gewater,	; City or Town, MD 210	. <i>State, Zip (</i> 03 <b>7</b>	Code)	
re,	of Heal		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place	ne)	Date	20c. Location	- City or Tov	wn, State	
E C	Pages nent of I ant: If ite		1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		rematory	5-8-	07	Edgewat	ter, M	1D	
3alt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee		22. Name and Addre		-				
	<u>0</u> 05 # 0		white all		2973 Solor						
		S 18	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final	d the death. Do not el	0		or respiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	ency	Canc	er			/	4 money	
	Examiner		Duy to yor a	s a consequen of):							
	id Ras	ner	Sequentially list conditions, and the conditions of the conditions	s a consequence of							
	scuted Ind transi	Examiner	triat initiated events					<u>.</u>			
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and hage 2 should be detached for use as the burial-transit		Due to (or as	a consequence of):							
687	ficate physi s the b	dical	d								
Box (	leath certific attending p	Physician/Med	IF FEMALE: 23c. If yes, outcome 23c. If yes, outcom					23d. Da	te of deliver	v	
	death le atte	icia	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)					Day Year	
P.0	at the I by th stache	hys	9 Unknown 9 Unknown								
	ires that the de signed by the a be detached t	ρ	Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause give	en in Part I.		/		e cause of death?	
Ö	v require been sig should t	eted	- For			-	1 □ Y€			ably 4 □Unknown	
Vital Records,	sician: The law certificate has b irector, page 2 s	Completed					24a. Was ar autops perforn	У	Were autop prior to com death?	sy findings available apletion of cause of	
ta Ta			25. Was case referred to medical			26. Place of Deat	1∐ Yes 2	€ No		2□ No	
	lysica is cer direct	To Be	examiner?	ent 2 ☐ ER/Outpatio	ent 3 DOA Otho				er (Specify)	Brothers	
0	or Attending Physician: ufter death. Director: After this certifici in by the funeral director,		27. Manner of Death 28a. Date of Inj Matural 5 Pending (Month, D.	ury 28b. Time ay <i>Year</i> ) Injury	UI ZOU. IIIJUI	y at k?	28d. Describe ho	w injury occur	red	Home	
Sio	tendi leath. tor: A the fu	catic	2 Accident Investigation		M 1 🗆	Yes 2 □ No					
Division or	after of Direct I Direct of In by	Certification:	determined 286. Place of In	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Sti City or Town		er or Rurai	Route Number,	
	spita hours ineral y filled		29a. Certifier Certifying Physician: To the best	of my knowledge, dea	ath occurred at the tir	ne, date and place,	and due to the ca	ause(s) and ma	anner as sta	ated.	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in L	Medical	(Check only one) 2 Medical Examiner: On the basis and manner s	of examination and/or i	investigation, in my o	pinion, death occur	red at the time, d	ate and place,	and due to	the cause(s)	
	Voit To 1	Σ	29b. Signature and title of certifier		29c. License			O C		* '	
)			teathe Mani			7936	2	03 - 0	7-0	2007	
	1013		30. Name and address of person who completed cause of Heather D. Mannuel, M.D.	, , , , , ,		imore M	D 21220				
	Sta	te	31. Date filed (Month, Day, Year) MAY 0 9 2007	rar's Signature	nive., Dail	zmore, ru	V 7177A		<u> </u>		
	Registr	ar	MAT U 9 ZUU/	m & s	beet!						

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / De State of Maryland / De	partment of He ertificate of D		, ,	giene leg. No. ?	16000
	Discount of	14	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th (	3. Time of Death
基	Physicia /Medic		Lillian M. Matthews			May	5 2007	1835 ™
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L			4c. County of Dea	
40.			Southern Maryland Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda	Clint		8 Date of Birth		George's thplace (State or Foreign
Ŀ	Funeral Director		577-42-2876 1 M 2 T 74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 14	1932 Ma	ryland
	w w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	h the Maryland r 28a-f show r notified at	Į.		Mar1boro				1 ☐ Yes 21☑ No
	h the or 28a o notif	Directo	10e. Street and Number	10f. Zip Code		1	log. Citizen of What Co	ountry?
	tth wit 23a c ust be		15228 Marlboro Pike	20772			USA	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 □ ∨ S = 2 ⋈ No If ∨ S, Give ↑ ∨ Year or Dates;	3. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
215-0036	n 72 hour "natural dica Ex		15. Decedent's Education 16a. Dec	cedent's Usual Occupat	tion		16b. Kind of Business	/industry
7	C * B	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done du . DO NOT use retired)		ang		
2	be filed withir stal Hygiene. d other than event, the M	S	11th 0 H	ousekeepi		o /First Middle	Hotel Maiden Surname)	
Maryland		o Be	John Mason		Lillia:		•	
ar Z	should be tnd Menta s marked umatic ev	2		iling Address (Street ar				Zip Code)
Ž.	and 2 salth a n 27 ls er tra		Wendell Matthews(Son) 138	16 Carlen	e Dr. U	Jpper M	[arlboro,	Md. 20772
saitimore,	permit. Pages 1 and 2 should bu Department of Health and Mentz Important: If Item 27 is marked any injury or other traumatic en		20a. Method of Disposition  1 N Burial 2 Cremation 3 D Bemoval from State	position (Name of enatory of other place, n Cemeter	)	Date	20c. Location - City or heltenhar	Town, State
Balt	permit. Departr Importa any inj			₩mNameRevelese 821 West				
			23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying.	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  ACUTE MYOC	ARBIAL	INFARC	NOT		Onset and Death
	Examiner		Due to (or as a consequence of):  CORONARY	ARTITUM ?	NICEARA	=		
		ner	sequentially list conditions,	11-10104	71501130			
	ecuted and transi	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
8/00,	be existing	a E	Due to (or as a consequence of):					
200	ificate p phys	edic	d					
POX	attending for use a	Physician/Medical		B Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
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ecords, r	quires tha	þ	Part II. Other significant conditions contributing to death but not resulting in the HYPERTEWSION	underlying cause given	in Part I.		oacco use contribute to es 2 No 3 Pr	/
ည သ	faw re as bee 2 sho	plet				24a. Was a	n 24b. Were au	utopsy findings available completion of cause of
ב ב	: The cate h ; page	Completed				perfore	ned / death?	2 No
=	sician certifi rector	Be	25. Was case referred to medical examiner?  1	Other	26. Place of Deat			
5	g Phy er this eral di	٦. ح	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury a	4 Inursing Ho		ence 6 Other (Spe	cify)
200	arh. or: Aft	atio	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation		es 2 □ No			
22	al or Atte s after des al Directo ed in by th	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
		Medical (	29a. Certifier (Check only one)  1 ✓ Certifying Physician: To the best of my knowledge, de 2 ✓ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time investigation, in my opi	e, date and place, nion, death occur	and due to the c red at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	Voithi Com	Ž	29b. Signature and title of certifier	29c. License r			9d. Date signed (Mont	
	(30 /	) [	Jadrie	D40:	324	/	MAY 7, 20	<b>千</b> の
	NON		30. Name and address of person who completed cause of death (Item 23a) (Type TERRY JODRIE, MD 7503 SURRATS R		TON, MA	RULAND	20735	
	Stat	_	31. Date filed (Month, Day, Year) 32 legistrar's Signature				-	
	Registra	L Comment	MAT U 31 ZUU!   Killedore a 176 A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Marshall Mason 2007 10:30 p /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forestville Nursing Home Forestville Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. tx M 2 □ F **Director** Sept. 16,1928 Washington, D.C. 578-34-0825 78 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Prince Georges <u>Forestville</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a must b 2110 Brooks Dr. 20747 Funeral United States "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 [X]Yes 2 □ No 1 / 17 / 5 If Yes, Give Year or Dates: 1 / 16 / 53 2□No1/17/51 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Be Raymond Mason ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 <u>Lizzie M. Mason / Wife</u> 2110 Brooks Dr. Forestville, Md. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State = 5 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. Maryland Veterans May 14, 2007 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pikė/Forestville, Md. 20747 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Stroke the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 1∐ Yes 2 √ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No I Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital To the Hospital within 24 hours a To the Funeral I 29a. Certifier tal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

State Registrar (Check only one)

31. Date filed (Month, Day

MAY 10

29b. Signature and title of certific

Bahram Pishdad, M.D. 32. Registrar's Signatur

replated cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D51520

1328 Southern Ave. S.E. #310 Washington, D.C.

29d. Date signed (Month, Day, Year)

May 8, 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1.1)

			1 - For State Registrar	State of W		epartment of Certificate of			giene	1	109	30				
	Dhyai	aio m	1. Decedent's Name (First, Middle,	Last)				2. Date of De	ath	· · · · ·	3. Time o	Death				
	Physic /Med		FRANK	MATTHEWS					7, 2007	Year	9:00	АМ				
	Exam	iner	4a. Facility Name (If not institution,			4b. City, Town,	or Location of Death		4c. County o	f Death						
			Hebrew Home of 5. Social Security Number		gton ge (In yrs. last birth		ckville	C Data of Bir	MON'							
	Funera Directo		212-18-0324	1 <b>№</b> M 2□F		rs. Months Days		8. Date of Bird (Month, Da Sept.]	y, Year) 9,1920	9. Birthp Cour Ma	lace (State of stry) aryla	nd nd				
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside C	ity Limits				
	Mary -f sh	tō	MD Mont	gomery		Silver	Spring					2 <b>X</b> No				
	th the or 28e	Director	10e. Street and Number			10f. Zip Code	-13		10g. Citizen of Wi	nat Coun	itry?					
	th will	alD	11501 Febru	ary Circl	Le, #20]	20	904		U.S	5.A.						
	er dez Items	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp	ecify Yes or No Rican, etc.)	14. Race		an Indian.					
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show eny injury or other traumatic event, Items are Examinar must be notified at once.	l by F	1 ☐ Never Married 2 ☐ Married  Widowed 4 ☐ Divorced	I ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ No			Specify:		.ack					
	5-C	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. [	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of work	ina	16b. Kind of Bus	iness/Inc	dustry					
	21215-0036 of within 72 hours aff giene. The man "natural", or it the man "natural", or it the man and a few man a	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Janitor	ed)	9	Clear	ning	Ser	vice:				
	nd ille	BeC	17. Father's Name (First, Middle, La				18. Mother's Name	e (First, Middle,								
	yla ould b Ment arkec	10	Perry Matth	ews					William							
	Maryland nd 2 should be file lith and Mental Hy 27 is marked oth		19a. Informant's Name/Relationship	*		Mailing Address (Stree					71	0904				
	1 and 1 and Health	10	Joan Thompso 20a. Method of Disposition	n (Daught		.501 Febru	uary Cir	#201	,Silver	Sp	ring.	,MD				
	Baltimore, permit. Pages 1 ar Department of Heal mportant: If item any injury or othermore.		1 Burial 2 Cremation 3		cemetery,	crematory or other pla	100)		20c. Location - C							
	attir parime parime cortan injur		* 4 □ Donation 5 □ Other (Spe 21. Synatus of Emeral Service Loc		Kiverd	ale Park	ess of Facility SN	12/07	Riverd	ale	, MD	7				
	Be a gray on		Soge K.	Sword	lu fi	246 N.Wa	ashingto:	n St,R	ockvill	е,M	ме, Ра D <b>20</b> 8	35 <b>0</b>				
	*		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause in each li	d the death. Do no ine.	t enter the mode of dyi	ing, such as cardiac o	or respiratory ar	rest,		Approximate Interval Bety	veen				
	Pnysician /Medical		Inmediate Cause (Final issease or condition seuling in death)  a. A Court of Cause (Final issease or Condition seuling in death)													
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4	68760 ilicate be e g physician as the buria	dica	•	d						-						
5	OX 6	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy											
V	To affe affe	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of Month		-	'ear				
18	S, P.O. es that the degreed by the		Part II. Other significant conditions	contributing to death b	ut not resulting in ti	ne underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	ute to the	a cause of de	eath?				
A.A.	cords, v requires been sign should be	ted by						1 🗆 Y	~1		bly 4 □U					
M	Recol	Completed						24a. Was a autops	sv prid	r to com	sy findings a	vailable use of				
	Vital Rouldler The Interpreted to rector, page		25. Was case referred to medical					perform 1 ☐ Yes	1 dea 2 440 1 C	th? Yes 2	2 No					
	of Vita Physicien: this certific al director,	o Be	examiner?	Hospital: 1 Inpatie	ont 2 ☐ ER/Outpa	Ott	26. Place of Death		100							
`	VISION Of VITA Attending Physicien: r death. setor: After this certified by the funeral director,	T:U	27. Manner of Death	28a. Date of Inju	ry 28b. Tim	ne of 28c, Injur	y at 2		ence 6 Other							
	ISION Ittending death. ctor: After	atlo	Natural 5 Pending investigati	on	<i>y Year)</i> Inju		Yes 2 □ No									
i	DIVISION of VITAI If or Attending Physicien: after death. Director: After this certificat d in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Inju building, etc	ury - At home, farm c. (Specify)	, street, factory, office	2	28f. Location (St City or Town	treet and Number n, State)	or Rural	Route Numb	er,				
	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical C	29a. Certifier (Check only one)  (Check only one)	hysician: To the best of miner: On the basis of	examination and/c	eath occurred at the tire investigation, in my control	me, date and place, a	and due to the ca	ause(s) and mann ate and place, and	er as sta	ted.					
-	Fo the vithin of the omple	Mec	29b. Signature and title of certifier	and manner sta	itoù.	29c. Licens			9d. Date signed (/							
	->-0		> Atuersa	Q(11)111	1)	Don	18051	$f = \int_{\Lambda}$	1 Au n	7	700	7 -				
	2		30. Name and address of person who	completed cause of de	eath (Item 23a) (Ty	pe, Ppfnt)	1000		0	$T_{ff}$	000-					
			DINESH 7	>- PATE	EL NO	6121 M	ON The SE	140, 1	Lo clevi	UE	10)20	0852				
	Sta Regist	100	31. Date filed (Month, Day, Year) MAY 1 0	2007 32. R tra	ar's Sionature	Least .		/		7						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MERCER 7, MAURICE C. MAY 2007 10:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9916 Walker House Road, #6 Montgomery Village MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 18, 1961 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** MM 2 F 45 **Director** 220-80-8114 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9916 Walker House Road, #6 Funeral 20886 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Genesis Family filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the once. 12th Moving Co Self-employed 17. Father's Name (First, Middle, Last) 18. Mcther's Name (First, Middle, Maiden Surname) Be Unknown Marion P. Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) Denise Mercer (Wife) 9916 Walker House Rd, #6, Montg. Village, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ash Memorial Cem 5/12/07 Sandy Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service No 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hepatic Carcinoma disease or condition/ resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury ner Due to (or as a consequence of) The law requires that the death certificate be executed Exami that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 □ No P.0. ed by the detached 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2√2 No 3 ☐ Probably 4 ☐ Unknown Alcoholism Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 X Natural 5 ☐ Pending investigation Injury nours after death.

Ineral Director; Af

y filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Hospital Medical 29a. Certifier 1X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cump, PHYSICIAN Mulson D43869 5-9-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11908 Darnestown Rd, St D, N. Potomac, MD20878 Nelson L. Lui, M.D. 31. Date filed (Month, 32. Registrar's Signature Day, Year) State 1 0 2007 Registrar

r.O. DOX 86/00,	ospital or Attending Physician: The law requires that the death certificate be executed the process of the proc		ly filled in by the funeral director, page 2 should be detached for use as the burial-transit
DIVISION OF VIRAL INSCORDS, F.O. DOX 00/00,	ospital or Attending Physician: The law requires thous after death	uneral Director: After this certificate has been signed by the attending physician and	funeral director, page 2 should be c

		For State Registrar		State	of Marylar	-	artment of H rtificate of I		nd Mer		giene 2	007	15937
Physic /Medi		1. Decedent's Nam Peggy T		· ·						Date of Dea Month May	Day	Year 2007	3. Time of Death 8:30p M
Exami		4a. Facility Name (/		-	umber)		4b. City, Town, or				4c. Co	unty of Death	<u> </u>
Funeral Director		5. Social Security N 424–40–84		6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. <b>73</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birtl (Month, Day ug. 10	h, Year) 0, 1933	Cour	place (State or Foreign htry) bama
a-f show	ctor	Usual Residence of 10a. State MD	10b. County	Arundel	10c. Cit	ty, Town or Lo					<u>.</u>		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
7 / 2 nours affer death with the Waylan "natural", or items 23a or 28a-f show adical Examiner must be notified at	eral Director	10e. Street and Nu					10f. Zip Code 21(					of What Cour	
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be med within 72 no ntal Hygiene. ed other than "natu event, the Medical	Completed	(Special Special <del></del>	grade completed	(1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Preside	during most o I)	of working		P. 7	of Business/Ind F. Morg er Comp	gan	
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Health and Health and Hem 27 is m		James B. 20a. Method of Disp	. Morgan	p (Type. Print) n/Husband		52	ng Address (Street and Street and			Ar	mold,	MD 21 on - City or To	012
Department of Important: If it any Injury or o		1⊠Burial 2	☐ Cremation 5 ☐ Other (Sp		n State	cemetery, crer	Mem. Garo  Name and Address	dens	May 9 200	9,	David	lsonvil	le, MD
hysician and burial-transit the prival-transit	edical Examiner	23a Part1. Enter I shock, or hea immediate Cause disease or condition resulting in death)  Sequentially list contant, leading to improve that initiated events resulting in death) I	railure. List of Final n n n n n n n n n n n n n n n n n n	ab	each line.	uence of):	erranco 895 Gov. R	g, such as ca			rest,		uneral Home MD 21146  Approximate Interval Between Onset and Death  3 years
y the attending packed for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 № 9 ☐ Unknown	months?	1□Live	utcome pf pregna birth 2 □ Feta gnant at time of d nown	l death 3□	]Ectopic pre <b>g</b> nancy ] Other (specify)				23d.	Date of delive Month	ory Day Year
en signed b	ed by	Part II. Other signif		s contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did to			e cause of death?
ifficate has b	e Complet	25. Was case referi	red to medical					00 81			sy med? 2 <b>X</b> No	tb. Were autoperior to condeath?  1 ☐ Yes	osy findings available npletion of cause of 2 \square
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To B	examiner? 1  Yes 2   27. Manner of Death 1 Natural 2  Accident 3 Suicide	No	28a. Date (Moi	e of Injury nth, Day Year) e of injury - At ho	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 LI Nursii	28d.	5 Reside	ence 6 o		r) I Route Number,
hours afte uneral Dir		4 ☐ Homicide  29a. Certifier (Check only	1 <b>X</b> Certifying	Physician: To th	ding, etc. (Specification)  e best of my kno	wledge, death	n occurred at the tim	ne, date and p	place and	due to the c	auco(c) and	manner as st	ated.
within 24 <b>To the F</b> complete	Medical	one) 29b. Signature and		and mai	nner stated.		29c. License	number	- Cocurred a			gned (Month, I	
J.	2	30. Name and addre					Print)	61711			May	4,200	
Sta Registr	~	31. Date filed (Mont		32.1	Reflistrar's Signa	ture	STREET LR	-OT KEEN	1186	DALTIM	ICE MA	-cycm	21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 Month **Physician** Robert Koons Mathias May 8, 10:55 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1000 Weller Circle, apt. Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 1924 82 Mary Tand 219-14-7890 Director Usual Residence of Decedent with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at Maryland Carroll Westminster 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 **USA** 1000 Weller Circle, apt. 207 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry J. Mathias Janet Viola Koons ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Yvonne Mathias, wife 1000 Weller Circle, apt. 207, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. John's (Leisters) 5/11/2007 1 Burial 2 □ Cremation 3 □ Removal from State Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home M01191 K 91 Willis Street, Westminster, MD 21157 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3/4/07-95/5/64 nin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending plant for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed? 2 No Attending Physician: after death.

Director: After this certifical in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Definesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 NO Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital of within 24 hours af To the Funeral D completely filled in filled i Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

NJL 10,10 29b. Signature and title of certifier

31. Nate filed (Month, Day, Year)

MAY 09

Day

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

a to Street (

29d. Date signed (Month. Day, Year)

DESTHINGTON IND 21157

		1 - For State Registrar	·	Department of Health and Certificate of Death	Mental Hygie		16939
Physici /Medio		1. Decedent's Name (First, Middle, La	ic. Coy, SR.		2. Date of Death	Day 2007	3. Time of Death 3.30 PM
Examin Funeral Director		107 20 1123	STREET 7. Age (In yrs. last bir	4b. City Town, or Location of Deat  A LISBURY  thday) If Under 1 Year If Under 24 Hrs  Wonths Days Hours Min.	/	4c. County of Death*  V 1 CO N  9. Birthp  730 PEN	11CO place (State or Foreign ptry) NSY/VAN1A
Maryland -f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  WICOM	10c. City, Tow SAL	n or Location		1	0d. Inside City Limits 1 XYes 2 □ No
death with the Maryland me 23a or 28a-f ehow triust be notified at	ai Director	10e, Street and Number 628 HOMER	Street	101. Zip Code 21804	10g.	Citizen of What Coun	ntry?
or its	by Funerai	11. Marital Status  1 Never Married 200 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 DYes 2 DNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen  1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
within 72 hours ene. than "natural", he wed fall Ex	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) 16a.  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired)	rking 16b	kind of Business/Inc Lity of SA	,
VIBRO A	To Be Co	17. Father's Name (First, Middle, Last			ne (First, Middle Maid		risbury
re, Mar s 1 and 2 sho f Health and Item 27 is m other traums		19a. Informant's Name/Pelationship (Barbara McCo) 20a. Method of Disposition	Type, Print)  Y/Wife  19b  20b. Place of	. Mailing Address (Street and Number or Ro 28 Homer Street, Disposition (Name of	Salisbui	ity or Town, State, Zip	21804
DEALLIMO permit. Pages Department of importent: If I eny Injury or If		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special Service Licenter)	WD V	A. CEMETERY 05/16  22. Name and Address of Facility / 3		Y ROAD-	ND SALISBURY
		23a. Part 1. Enter the disease, or constock, or near failure. List only	D. FOULA plications that caused the death. Do none cause on each line.	not enter the mode of dying, such as cardiac	Chapel or respiratory arrest,	MD	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	ach Cance:	7		7 months
xecuted and il-transit	Examiner	Sequentially list conditions, if any, reacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence)  Due to (or as a consequence)				
OX OX OU, certificate be executed rding physicien and use as the burial-transit	dicai		. d				
w requires that the death certific been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ory Day Year
wrequires that the death been signed by the atter should be detached for u	ed by Pi	Part II. Other significant conditions of Diabeles, K	ontributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobaco	co use contribute to th	ne cause of death? ably 4 Munknown
The lay	Completed by	hypertension,	dementia, an	emia	24a. Was an autopsy performed 1 Yes 2	l? death?	psy findings available mpletion of cause of
this aldir	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) I	- 1 Out	th Check only one lome 5 Residence 28d. Describe how in		v)
To the Hospital or Attending F within 44 hours atter death. To the Funeral Director: After pmpletely filled in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	I Route Number,
the Hospi hin 24 hou the Funer npletely fill	Medicai	one) 2 Medical Exam	ysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	o, death occurred at the time, date and place d/or investigation, in my opinion, death occu	rred at the time, date	and place, and due to	the cause(s)
£3£5		29b. Signature and title of certifier	(Physica	29c. License number  Doo 52255  Type, Print)  hosafeal Dr. Ca		Date signed (Month, 1	
Sta	te	30. Name and address of person who Muhammad (2) 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (  83 &	hosafeak Dr. Ca	mbridge	, MD 2	1613
Registr		MAY 0 9 2	32. Registrar's Signature	Jan 2			

ORIGINAL

			1 _ State	•			nd Mental H	ygiene	
			Registrar  1. Decedent's Name (First, Middle, Last)	<i>Ce</i>	rtificate of	Death	0.0-160	Reg. No.	/ 15940
F	Physici /Medio		TIMOTHY MUNS	HAUR			2. Date of D Month MAY	17, 200 <sup>Yea</sup>	3. Time of Death 8:39 P M
	Examin		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITA	L	4b. City, Town, o		Death	4c. County of De FREDER	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (	In yrs. last birthday 50 Yrs.	If Under 1 Year   Months   Days	If Under 2 Hours	Min. (Month, E	9. B Day, Year) 24, 1956Pen	irthplace (State or Foreign Country)
b	n de u		Usual Residence of Decedent	JU			NOV.	24, 1950ren	iiisyivaiiia
	ırylan ihow i at	_	10a. State 10b. County 1	0c. City, Town or L	ocation				10d. Inside City Limits
	ne Ma 8a-f s	Director	Maryland Carroll			minste	er		1 ☐ Yes 2 🛣 No
	with the		10e. Street and Number		10f. Zip Code			10g. Citizen of What (	
	eath y	eral	527 Old Manchester Rd.	arin II S 13	Was Doodoot of L	21157	in? (Chooify Voc or N	U.S.A lo- 14. Race - Am	-
136	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent Ever Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	# # U.S.   13.	1 ☐ Yes 2 ☒ No		in? (Specify Yes or N Puerto Rican, etc.)	Black, Wh	nite, etc.
9200-91212	2 hou	ted	15. Decedent's Education	16a. Dece	edent's Usual Occup	oation		16b. Kind of Busines	/hite s/Industry
7	thin 7 e. an "n Medi	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	during most d)	of working		
	ed wi ygien ier th	Completed	12		salesm			auto par	ts
yland	0 = 0 %	Be	17. Father's Name (First, Middle, Last)				's Name <i>(First, Middl</i>		
	hould d Mer narke natic	잍	Carlton E. Munshaur  19a. Informant's Name/Relationship (Type. Print)	10h 14ail			Sue Ellen		
Mar	nd 2 s Ith an 27 Is i traui		Sue E. Munshaur/ mother		Bark Hil			ber, City or Town, State,	
ē,	f Heal	1	20a. Method of Disposition		osition (Name of ematory or other place		Date Date	ridge, MD 2	
E	Pages lent of nt: If i		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ty Cremat		/18/2007	Sykesville	MD
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.		21. Signature of Fluneral Service Licenses	2	2. Name and Addre	ess of Facility	Hartzler	Funeral Homidge, MD 21	ne
	12 36		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate
	Physician		Immediate Cause (Final disease or condition		t				Interval Between Onset and Death
	/Medical		resulting in death)  a. 21  Due to (or as a co		51	,			
	Examiner		Sequentially list conditions. b. Alcoh	obic 1	iver a	21154	ase		
1	ed sit	iner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events	unsequence of).					
P	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last C	onsequence of):					
8/00,	cate be executed physician and the burial-transit		3333	3.1.00 qua.1.00 0.1/s.					
00	fficate g physi	edical	d						
O. DOX	The law requires that the death certifi te has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	у		23d. Date of do Month	elivery Day Year
ŗ.	that the by detac		Part II. Other significant conditions contributing to death but r	ot resulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ecords,	requires een sigr	ted by	Anemia.				1	Yes 2□No 3□F	Probably 4 Onknown
	a 8 2	Completed					24a. Was auto perf 1□ Yes	opsy prior to death?	autopsy findings available completion of cause of
ם מ	Physiclan: r this certifica ral director, I	Bec	25. Was case referred to medical examiner?			26. Place of	of Death (Check only		3 2 110
5	hysik this co	흔	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 PR/Outpatie		4 🗆 Nurs		sidence 6 Other (Sp.	ecify)
	After Unerg	.io	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Y	ear) 28b. Time o	Wor			how injury occurred	
10101	death ctor: / the	icat	2 Accident investigation  3 Suicide 6 Could not be 28e. Place of injury.	- At home farm et		Yes 2□N	-	/C4ma4 a - d 41	7
2	after Direction by	Certification:	4 Homicide determined building, etc. (	Specify)	reet, factory, office		City or To	(Street and Number or F own, State)	nurai Houte Number,
	To the Hospital or Attending Physiclan: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of real part of the best of the	amination and/or in	h occurred at the tir	me, date and opinion, death	place, and due to the n occurred at the time	e cause(s) and manner a	as stated. ue to the cause(s)
	To th Within To th COMP	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
			I luce min		3000	6041	7	5/18/07	,
	2	Ì	30. Name and address of person who completed cause of deat	, , , , ,	Print)			, , , ,	
	۲			nas To	husan	DV,	Frederic	cic Mb	21702
	Sta Registra		31. Date filed (Month, Day, Year) 1 32. Registrar's	Signature	9	,			
	negistr	म	\$15V 9 A 2007 Pages &		8				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistraMEND#23a, Pt. 1&2, perMD, 5/10/07, DPS, Mcertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MAY 05, MARSHALL A. NARVA 2007 4:28 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CASEY HOUSE ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 039-20-2505 Director 76 JULY 13, 1930 RHODE ISLAND Usual Residence of Decedent with the Maryland a or 28a-f show be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1√ Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a 2 INFIELD COURT SOUTH 20854 "natural", or items 23a U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Many injury or other traumatic event in the Many injury or other traumatic event in the Many injury or other traumatic event in the Many injury or other traumatic event injury or other event injury or other e 5+ RESEARCH PYCHOLOGIST FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL NARVA REVA REZNICK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADELE NARVA/WIFE 2 INFIELD COURT SOUTH, ROCKVILLE, MARYLAND 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🖾 Removal from State Ò KING DAVID MEMORIAL 05/08/2007 FALLS CHURCH, VIRGINIA 4 □ Donation 5 □ Other (Specify) 21. Sign up of Fundal Solvice Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. EDWARD SAGEL FUNERAL DIRECTION 1091 ROCKVILLE PIKE, ROCKVILI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE RENAL FAILURE Secsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pleural space Methicillin Resistant Staphylococcus Aureus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Chronic obstructive pulmonary disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1∐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify)HOSPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this after death.

I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or within 24 hours aft

To the Funeral DI

completely filled in 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DM. Helliama H0058032 MAY 6, 2007 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA M. MILLIAMS, D.O. 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Regstrar's Signature

2007

10

			1 - State of Maryland State of Maryland		rtment of H		l Mental Hy	giene Reg. No. 2	107	16	942
P	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De		Vone	3. Time of	Death
	Physici /Medic		John Richard O'Connor				May	8, 20	007	7:30	АМ
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		ath	4c. County			
-	Funeral		The Arbor at BAywoods of Annapol  5. Social Security Number 6. Sex 7. Age (In yrs. las:		Annapoli		rs. 8. Date of Bir	Anne		del lace (State o	r Foreign
b	Director		107-09-7630 1™ 2□F 88	Yrs.	Months Days	Hours Mi	n. (Month, Da	27,1918	Coun	York	ruleign
	pu ,		Usual Residence of Decedent				041) 2	7,1710			
	faryla shov	ō	10a. State 10b. County 10c. City, T	own or Loc	cation				1	0d. Inside Cit 1 □ Ves	-
	the N 28a-f notifie	Director	Maryland Anne Arundel Ann	apoli	S 10f. Zip Code			10g. Citizen of V	What Cour	1 ☐ Yes	XX
	3a or st be	Ϊ́	7101 Bay Front Drive Apt 4411		21403	3		United S		-	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuba		(Specify Yes or No	)- 14. Rac	e - Americ	an Indian,	
9	or ite		1 ☐ Never Married 2 ☐ Married XX Yes 2 ☐ No	- 1	Yes XX No	Specify:	erio Hican, etc.)	Specify	k, White,	ite	
Ö	hours tural"	ed by	Year or Dates: WWII		ent's Usual Occupa						
7	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	plet	(Specify only highest grade completed)		kind of work done d OO NOT use retired)		orking	16b. Kind of Bu	siness/Inc	lustry	
212	d with giene er tha	E O	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Mi	crobiolog	gy		Pharma	aceut	icals	
D	be file tal Hy d othe	Be Completed	17. Father's Name (First, Middle, Last)				ame (First, Middle				
З	12 should be filed wand Mental Hygie Is marked other tranmatic event, th	P P	Richard O'Connor			Anna Mo					
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at				g Address (Street a ogers Ave					Code)	
ē,	s 1 and f Health tem 27 other tr		20a. Method of Disposition 20b. Place	e of Dispos	ition (Name of	1	Date	•		wn, State	
E	Pages nent of h ant: If Ite ury or of		Light   Ligh		natory or other place emetery	1	12/2007	20c. Location - Johns Nor	són C v Yor	ity L	
ati	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		Name and Address						.Inc.
<u></u>	8 3 E 8 8		Mechal Ila	14	7 Duke of	Glouce	ester St.	Annapo	olis,	MD 21	401
H			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	5000			rrest,		Approximate Interval Bety	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	me	rs W	1329	59			9 xea	eath s
la-	Examiner		Due to (or as a consequen	ce of):							
	20	e.	Sequentially list conditions, bb	ce ofj:							
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.								
Ö,	cate be executed bhysician and the burial-transit		resulting in death) Last  Due to (or as a consequen	ce of):							
8760	icate b physic s the bi	dical	d								
9 X	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy	,							
ROX	death atter	cian	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive nth	-	ear
<u>.</u>	t the c by the ached	hysi	9 Unknown								
S,	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause give	n in Part I.	23e. Did t	obacco use contr	ibute to th	e cause of de	eath?
o	requir						. 10	Yes 212 No	3 Proba	ably 4 □U	nknown
Kecords,	e law has b	Completed					24a. Was autop	osv p	rior to con	sy findings a	vailable use of
VITAL	G 17						perfo 1□ Yes	rmed? d 2X No 1	eath? □Yes	2 □ No	
	Physiclan: this certific	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EB/	/Outpationt	3 DOA Other	n 14	eath (Check only o				
ö	utending Phys death. ctor: After this the funeral dir	$\vdash \oplus$	27. Manner of Death 28a. Date of Injury 28	b. Time of	28c. Injury Work		Home 5 ☐ Resid	dence 6 ∐Othenow injury occurre		)	
Sion	Attending r death. ector: After by the fune	atio	Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		? ′es 2 □ No					
Š	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Number	er or Rural	Route Numb	per,
_			29a. Certifier MCertifying Physician: To the best of my knowler	des desth		- 1-1-	1				
	e Hospital or Attend 24 hours after death, e Funeral Director: A etely filled in by the fi	edical	29a. Certifier (Check only one) (Check only one)	and/or inv	estigation, in my op	e, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as stand and due to	ated. the cause(s)	
	e = e a	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month, L	Day, Year)	
1	1		I Want Be un MY	2	DOD	1295	71	05/08	7/2	007	
	1000	N	30. Name and address of person who completed cause of death (Item 23.	a) (Type, P	rint)		//	CIAR	40		_
	100		Pavl Berez MD 2225 31. Date filed (Month, Day, Year). 32. Segistrar's Signature		Vete	nse	Hwy	Crot	TUI	n	D
	Stat Registra		31. Date filed (Month, Day, Year) 32. Segistrar's Signature MAY 0 9 2007	A	ale						

Physician Medical Esther V. Orndorff  ## Facility Name (If not institution, give street and number)  ## Facility Name (If not institution, give street and number)  ## 5502 Harris Farm Lane  ## Funeral  ## Director  ## 10			1 - For State Registrar	State of Ma		epartment o Certificate			Reg. No.	211111	1694
ESTINET    Setting   Various   Vario	Physicia	an	1. Decedent's Name (First, Middle, Las	t)						Year	3. Time of Death
550.2 Harris Parm Lane  100 Color Service Humber of Co		_	Esther V. Or	ndorff				May 7			11:50A
2. Stock Security Number 2. Stock Security Num	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	m, or Location of De	ath	4c.	County of Death	ı
205 -10 - 210   10 c Clark  Main Resource of December   10 c Clark   1		90)S		rm Lane							
Section   100	4					Months Da		in. 8. Date of B	lirth Day, Year)	9. Birth	place (State or Foreig
The State   100-County   100-Co	Director-		205-10-2102	J. 200	85 <sup>*</sup>	rs.		Feb.1	7,19		
The specify Clark Americal Part Notes (1986)   Specify White	and *				10c City Town	or Location					10d Inside City Limit
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The specify Clark Americal Part Notes (1986)   Specify White	he N	ect			Cla						
The specify Clark Americal Part Notes (1986)   Specify White	with										•
The specify Clark Americal Part Notes (1986)   Specify White	• 23	rai			i- 11 C			10 11 11			
Selection of the control of the co		by Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		If Yes, specify	Cuban, Mexican, Pu	erto Rican, etc.)		Black, White	, etc.
Selection of the control of the co	ature cert				16a. 1	Decedent's Usual Oc	cupation		16b. Kir		
19	g - 3	per				Give kind of work do	one during most of v	vorking			
19	the second	E		College (1-4or 5+	-)	Homem	aker		D	rivato	
Part   Description   Descrip	Hygie other	O	17. Father's Name (First, Middle, Last)			1101110111		lame (First, Middl			
The Pattison/grandson and the continue of the	a a a	0	Curtis I. Th	rone			Anna	Stalow			
TIM PATELISON/Grandson Collumbia. Md 21045  20 Method of Dispection  1 Burial 2 & Cremation 3 Removed from State  210 Piezo of Dispection (Plane of Long-topic)  211 SportTop of Funeral Service Learning.  212 Name and Address of Facility Hodges & Edwards F. H.  213 SportTop of Funeral Service Learning.  223 A facility Figure the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, interval Benevies Learning and the death of the de	nd M	-			19b.	Mailing Address (Sti	reet and Number or	Rural Route Num	ber, City or	r Town, State, Zi	p Code)
Contains of College (Section of School (Section of School)   Contains of School (Section of School)	Trac		Tim Pattison/g	randson	95	20 Wand	ering Wa	ay_			,
Continue of State   Cont	Hea tem othe	ļ			20b. Place of	Disposition (Name o	, Ma. 210	Date	20c. Lo	cation - City or T	own, State
232. Fig. Enter the disease or conceitations that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate Consett and Death Conse	y or									D	-1- 14-1
232. Fig. Enter the disease or conceitations that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.  Approximate Consett and Death Conse	artme injur				KIVEL						
23a Payh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, and control of the cause of conditions and caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, and control of the cause or each time. The control of the cause of conditions and caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.    Approximate Consequence of the cause of conditions and caused the death of the caused of	eny eny		Davies.	1 11.	als!						
PASIGNATION OF THE FRANCE CONTINUENCE OF THE CONTIN	(mg	-	23a Parti. Enter the disease or comp	lications that caused t	he death. Do no					trand,	
Macdical xaminer    Machiner   Sequentially list conditions are consequence of  :			shock, or neart failure. List only o	one cause on each line	).	or enter the mode of	dying, such as card	iac or respiratory	arrest,		Interval Between
Sequentially list conditions, if any, leading to immediate the post light of the pos		=	disease or condition				Fr.				
Sequentially list conditions of any leading to memodiate cause. Enter Underlying Cause glueses or many any leading to memodiate cause. Enter Underlying Cause glueses or many any leading in death) Last  Due to (or as a consequence of):    Comparison of the cause of			(			f):					A
The surface of Death (Check only one)  The surface of Dea		_	Sequentially list conditions,	U							Monthy
The surface of Death (Check only one)  The surface of Dea	- TE	ine	cause. Enter Under vin	1979							•
FEMALE:   23b. Was decodant pregnant in the past 12 months?   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Ves   2   No   3   Probably   4   Unknown   9   Unknow	and I-tran	хап	that initiated events	U		<del></del>					Jeans
FFEMALE   23b. Was decedent pregnant in the past 12 months?   10 was put 2 months?   10 w	cian	H		Dua to (or as a	consequence of	J.					
FEMALE   23b. Was decoded pregnant months   23c. It yes, outcome of pregnancy   1.0 we birth 2   Fetal death   3   Ectopic pregnancy   1.0 we will be birth 2   Fetal death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   23b. Was decoded not pregnant months   23c. It yes, outcome of pregnancy   1.0 we will be birth 2   Fetal death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   23b. Was decoded not pregnant   1.0 we will be birth 2   Fetal death   5   Other (specify)   23d. Date of delivery   Month   Day   Year   23d. Date of Delivery   Day   Date of Delivery   Day   Date of Delivery   Day   Date of Delivery   Day   Date of Delivery   Day   Date	the	음		d							
Security   Security		40	IF FEMALE:	220 If you system of	f =======						
9   Unknown 9   Un	or us	lan	230. Was decedent pregnant	1 Live birth 2	Fetal death				2		*
24a. Was an autopsy findings availating the performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1   Impatient 2   ER/Outpatient 3   DOA   Other 4   Nursing Home 5   Residence 6   Other (Specify)  27. Manner of Death 1   Xaltural 5   Pending investigation 3   Suicide 4   Homicide   Getermined   Check only one)  28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   1   Yes 2   No   28c. Injury at Work?   1   Yes 2   No   No   No   No   No   No   No	the e	/sic	1 ☐ Yes 2 📉 No		me of death	5 Other (specif)	")			WORLD	Day
24b. Was an autopsy findings availal prior to completion of cause of death?  25c. Was case referred to medical examiner?  1   Yes   2x  No  26c. Place of Death (Check only one)  27c. Manner of Death  1   Yes   2x  No  28c. Injury at   Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, fill of period of the cause (s) and manner as stated (sheet)  29d. Certifier  29d. Certifier  29d. Signature and title of certifier  29d. Signature and title of certifier  29d. Date signature  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, fill of the cause (s) and manner as stated (sheet)  29d. Date signature	d by	Æ		-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1							
24a. Was an autopsy findings availating the performed?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1   Impatient 2   ER/Outpatient 3   DOA   Other 4   Nursing Home 5   Residence 6   Other (Specify)  27. Manner of Death 1   Xaltural 5   Pending investigation 3   Suicide 4   Homicide   Getermined   Check only one)  28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes 2   No   1   Yes 2   No   28c. Injury at Work?   1   Yes 2   No   No   No   No   No   No   No	engine bed	ן ב			not resulting in	the underlying cause	given in Part I.				
25. Was case referred to medical examiner?  26. Place of Death   Check only one    27. Manner of Death   1   Month, Day Year    28. Date of Injury   28b. Time of Injury   28c. Injury at Work?  28. Date of Injury   28c. Injury at Work?  29. Certifier   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated    29. Certifier   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated    29. Certifier   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated    29. Certifier   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated    29. Certifier   1   Ce	bluo.	ted						- 1	Yes 25	MANO 3∐Pro	bably 4 ∐Unknow
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Manner of Death   Month, Day Year   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   27. Manner of Death   Month, Day Year   28b. Time of Injury   28c. Injury at Work?   28c. Date of In	as b	e e	osteo antinit	15'						24b. Were auto	opsy findings availab
25. Was case referred to medical examiner?  1	ate h	5						peri	formed?	death?	
State	rtific Stor,	0	25. Was case referred to medical				26. Place of D				
1   XNatural   2   Accident   3   Suicide   4   Homicide   4   Homicide   29a. Certifier   29a. Certifier   29a. Certifier   29a. Certifier   29a. Certifier   29a. Signature and title of certifier   29b. Signature and difference of positions of person who completed cause of death (Item 23a) (Type, Print)   X Certifier	direc			Hospital: 1 ☐ Inpatient	t 2 ER/Outp	patient 3 DOA	Other			Other (Speci	(v)
22 Accident 3 State 2 State 2 State 3 State 2 State 3 State 2 State 2 State 3	er th			28a. Date of Injury	Year) 28b. Tip	me of 28c. I					
29a. Certifier (Chick only 29b. Signature and title of certifier  29b. Signature and dude to the cause (s) and manner as stated (Month, Day, Year)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.B. VELLANKI 8850, CCLUNBIA, 100 MACK NAY \$308, Columbia, M.D. 210 45  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ath. e fur	읉		(World, Day	1047 111						
29a. Certifier (Chick only 29b. Signature and title of certifier  29b. Signature and dude to the cause (s) and manner as stated (Month, Day, Year)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.B. VELLANKI 8850, CCLUNBIA, 100 MACK NAY \$308, Columbia, M.D. 210 45  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	oy th	2	determined	28e. Place of Injur	y - At home, farr	n, street, factory, off	ce	28f. Location	(Street and	Number or Rur	al Route Number,
29a. Certifier (Discovity one)  29a. Certifier (Discovity one)  29b. Signature and title of certifier (Discovity one)  29c. License number (Discovity one)  29c. License number (Discovity one)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.B. VELLANKI 8850, Celunbia, 100 Mark NAY 308, Columbia, M.D. 210 45  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	d in	er e	4 - Homede	building, etc.	(Зреспу)			City or 10	own, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)  N.B. VELLANKI, 8850, Columbia, 100 MARKWAY \$ 308, Columbia, M.D. 210 45  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	24 hours te Funere letely fille	dical	(Crieck only Z Medical Exam	iner: On the basis of a	examination and	death occurred at the for investigation, in n	e time, date and pla ny opinion, death oc	ice, and due to the curred at the time	cause(s) , date and	and manner as s place, and due t	stated o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.B. VELLANKI, 8850, Columbia, M.D. 210 45  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	omp	×	29b. Signature and title of certifier	1.					29d. Date	signed (Month,	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.B. VELLANKI, 8850, CCLUNBIA, 100 PARKNAY + 308, Columbia, Mp. 210 45  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature			I valled	à		D	1.3046	9	Ma	Y 81	2007.
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	12	F	30. Name and address of nerson who o	nmoleted cause of dea	ath (Item 23a) (T	vne Print)		-		/ 175	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Me		N.B. VELLANK 88	So, Colune	37A , 10	6 PARKWA	1y + 30	8. Colu	mbiq	, 90	21045
State	Cto	-		4.44			,		-		
117 Rev 1/2001											

			partment of Health and Mental Hygiene
		Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death Reg. No. 2007 6 944
Physi		Honry Onlotel	2. Date of Death  Month  Day  Year  Month  10 2007
/Med Exam	dical	A. E. Mile March Mr. C. C. C. C.	May 18, 2007 1650 P M  4b. City, Town, or Location of Death 4c. County of Death
LAGII		602 Skipjack Court	Elkton Cecil
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	
Directo	or	Usual Residence of Decedent	Aug. 1, 1922   Czechoslovakia
yland Iow at		10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limits
e Mar a-fsh tiffed	j	Maryland Cecil Elkto	n 1 <del>M</del> Yes 2 □ No
or 28	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
eath w	20		21921 United States
ter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Yes. 2 ☑ No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
036 iurs al al', or	2	3 ☑ Widowed 4 ☐ Divorced   If Yes, Give 1 Year or Dates:	1 □ Yes 2 No Specify: Specify: White
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thyer than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation 16b. Kind of Business/Industry e kind of work done during most of working
121 within sne. than '	au	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)
d 2 filed \ Hygie	ပိ	12 17. Father's Name (First, Middle, Last)	Waiter Restaurant  18. Mother's Name (First, Middle, Maiden Surname)
⊆ a a c ≥ ≤	To Be		Marie Opletalova
ary shou and N s mai	ļ	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
			Lansdown Court, Elkton, MD 21921
MOre Pages 1 nent of H int: If ite		Burial 2 Mcremation 3   Hemoval from State	ematory or other place)
	.:1		ris & Co., Inc. May 21, 2007   West Chester, Pennsylvania
Balt permit. Departi Importa any Inj	ouce	21. Signature of turieral service Licensee	Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory arrest.  Approximate
Physiciar	1	Immediate Cause (Final	Interval Between Onset and Death
/Medica		resulting in death)  a. Due to (or as, consequence of):	1 gear
Examine		Sequentially list conditions, b. LEUKEMIG	1 year
nsit ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
execunand and ial-tra	Exal	that initiated events resulting in death) Last c	
the death certificate be executed the attending physician and inched for use as the burial-transit	8		
x 68 ertifica ling pl	Medi	IF FEMALE:	
BOX 6  Beath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1	□ Ectopic pregnancy    Determine   23d. Date of delivery   Month   Day   Year   Year
the d	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)
cords, P.C. w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ord; equire en sig	ed k	neart august, hyperchile	1   Yes 2   No 3   Probably 4   Unknown
(1) E S C	Completed by		24a. Was an autopsy findings available prior to completion of cause of
VITAI HEC sician: The law s certificate has b irector, page 2 s	S		performed? death? 1 □ Yes 2 ▼ No 1 □ Yes 2 □ No
VITAI sician: T certificat rector, pi	Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   I   Innatient   2   EB/Outnatient   2   EB/Outnat	26. Place of Death (Check only one)
OF FPhyser this eral di	7: To	27. Manner of Death 28a. Date of Injury 28b. Time	4 Nursing Home 5 Hesidence 6 Other (Specify)
ath. rr: Afte	atior	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No
LIVISION I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	treet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dital o			
Hosp 24 hou Fune etely fi	Medical	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and/or one)  29 Medical Examiner: On the basis of examination and/or one)	th occurred at the time, date and place, and due to the cause(s) and manner as stated.  nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
. ,,,,		1 AZAU Im	DC059324 May 21,2007
2	ار	30. Name and address of person who completed cause of death (Item 23a) (Type	Print)
		Renee Perkis MO 111 W. Hryh St. Suit	JIY E/Ktn, NO 21921
S Regis	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	les services and the services are the services and the services are the se
3.0		MINING & COULD PROPERTY OF	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

			For State Registrar	State of	Marylar			nt of H		Mental Hy	giene	007	15945
	8		1. Decedent's Name (First, Middle, Last	)						2. Date of Dea	ath		3. Time of Death
	Physic		Volva Per	TU						Month	Day	2007	1:45 P M
r .	/Medi Examir		4a. Facility Name (If not institution, give	street and num	ber)		4b. Ci	y, Town, or	Location of De		-	ounty of Deat	h
1		. Z.	GOOD SAMAR	ITAN	HOSPI	792		BA	TIMO	RE		n/a	
	Funeral		5. Social Security Number 6. Se	x 7		last birthday)		ler 1 Year	If Under 24 H	rs. 8 Date of Birt	h	9. Birt	hplace (State or Foreign
¥	Director		169-24-5897	]M 2∭TF	77	Yrs.	Month	s Days	Hours M	n. (Month, Da Feb. 2	y, Year) 7.193	A   -	nsylvania
	P .		Usual Residence of Decedent										
	show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Sa-f s	cto	Maryland Cecil		R	ising	Sun						1 ☐ Yes 2 <b>X</b> No
	ith th	Directo	10e. Street and Number				10f. 2	Zip Code			10g. Citize	en of What Co	untry?
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	ens Ens	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	l.S. 13.	Was Dec	edent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)	. 14	Race - Ame Black, White	
36	or It	Y F.	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	No No			2 <b>X</b> No	Specify:			Specify: Wh	
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21215-0036	be filed within 72 hours atter death with the Maryla nal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			(Give	kind of 1	sual Occupa vork done d	urina most of w	vorking	16b. Kind	d of Business/	Industry
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Baltimore,	0 ° = >		1 X Burial 2 ☐ Cremation 3 ☐ F		tate	cemetery, crer	natory o	other place	· •				
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3al	Demit. I Departm Importar any Inju		21. Signatur Frieral Service Licens	1/C 11/19	1	22	2. Name	and Address	s of Facility R	.T. Foard	Fune	eral Ho	ome, P.A.
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ne cause on ea	used the deat ch line.	n. Do not ent	er the m	ode of dying	, such as card	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)		ras a consec								
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	ed sit	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ras a conseq								
	and and I-tran	Examiner	that initiated events resulting in death) Last		r as a conseq		en.	6-11	P05A1	REOMA			
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Вох	death certit e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	I death 3		pregnancy			23	<li>d. Date of deli Month</li>	very Day Year
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Division	Attending it death.	ertification:	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 No				
<u>≥</u>	i or Atten after deat Director: I in by the	Ē	4 Homicide determined	28e. Ptace o building	f Injury - At hi g, etc. <i>(Specif</i>	ome, farm, str y)	eet, facto	ory, office		28f. Location (S City or Tow		Numb <b>er</b> or Ru	ral Route Number,
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely tilled in by the	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Madical Examination	nar: On the bas	is or examina	wledge, death	occurre vestigatio	d at the time	e, date and pla- nion, death oc	ce, and due to the courred at the time of	ause(s) ar	nd manner as	stated. to the cause(s)
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	7. Vil.		29b. Signature and title of certifier	ATTON	DIMA	. 1		9c. License				signed (Monti	_
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	ris.		17 . 27 · ·	mpleted cause		n 23a) (Туре,	Print)	MAG	NIM	COIM	1.		
120	7		31. Date filed (Month, Day, Year)		AR (7	STO	125	PITAL	L + B	BACTIMO	KE		-
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** J. Pilkerton 05, 2007 Marion May 5:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlotte Hall VA Home Charlotte Hall St. Mary If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Months Hours Director 577-44-0357 74 10/23/1932 Pickins, S.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County show iral", or items 23a or 28a-f sho Examiner must be notified at 1 Yes 2 No Director Clinton MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 8600 Mike Shapiro Drive 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Is marked Tarol **Herickel** Smith Ella Ruth Lake Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hurt, VA 24563 Diane I. Coates/Daughter 936 Dews Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 05/10/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home, Hyper Mondonesy. Cheat Leas 3401 Bladensburg Road Bren Fartt. Buter the disease Ur compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Coronary Heart Disease burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Metastasis from Lung Cancer IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Vear 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2K No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Inpatient 1 Yes 2X No 2 ER/Outpatient 3 DOA 4

■ Nursing Home 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ∏Yes 2 ∏No death. 2 Accident To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760. P.O. Division or Vital Records. Hospital or Attending Physician: To the Hospital
within 24 hours a
To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

Ahmed Heshmat, MD 31. Date filed (Month, Day, Year) MAY 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29449 Charlotte Hall Road Charlotte Hall, MD 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

U00575

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 05 0218 67 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBUR reninsula Nicomico If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Days AUG. 21, Director 1945 MARYLAND Usual Residence of Decedent iit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan with of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-f show in ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 es 2 No Director COMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Westover DRIVE ted Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 Divorced Specify: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Beachamp Elementary/Secondary (0-12) College (1-4or 5+) UMBER CUTTER Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ttman 304 Pine St. Fruitland (NIECE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation Eden, md 4 ☐ Donation 5 ☐ Other (Specify) Depart import any ri Name and Address of Facility W. Isabella St Bennie Smith SAlisbury, md FUNET AL Home 23a. Part1. Exter the disea shock, or heart failure , e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CANDIDEMIA disease or condition resulting in death) 116EKS /Medical Due to (or as a consequence of): Examiner DEFICIENCY SUNDREME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transi and Due to (or as a consequence of): Box 68760 attending physician for use as the buris certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1⊟ Yes 2 ANO within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No 1 Ampatient 2 ER/Outpatient မှ 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury

(Month. Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO062916 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SVETT ANA GUNERREZ 1415 SOUTH PIVISION SUITE & SPRISKYZY MOZISBUY 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 2230 M 05 01 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur ) icomico If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□F Months Hours Min. Director 465-38-0855 75 7-30-1931 Texas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1K1Yes 2□No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 417 Virginia Avenue 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1951— If Yes, Give Year or Dates: 1952 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☒ No 2 Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 1952 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor <u>Education</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Jess Nealy Maybelle Bisonette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Vaughn - Representative 417 Virginia Avenue, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5-8-2007 Delmar, Delaware 22. Name and Address of Facility 21. Signature of Syneral Service Licensee Bounds Funeral Home Main Street, Salisbury, Maryland 21804 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural
Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

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To the Funeral Director: Aft IN MAP

To the Hospitai

DHMH 17 Rev 1/2001

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items 23a or 28a-f show iner must be notified at

72 hours after death with

Baltimore, Maryland 21215-0036

d 2 should be filed within 72 hours after d ith and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

that the death certificate be executed

Box 68760.

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Records,

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(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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page 2 s certificate has

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		State of Maryland / Departmen  Certificate	it of Health and M e of Death		ene 0 0 7	16949									
	Discontinuo	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Yea	3. Time of Death									
н	Physiciar /Medica	T		May 20,	2007	7:20 P.M.									
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		St. Vincent Care Center	Emmitsbu		Frede										
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24 Hrs. Days Hours Min.	(Month, Day, \	(ear) 9. E	Birthplace (State or Foreign Country)									
	Director	134-40-1914		Aug. 24,	1916 Wa	shington D.C.									
	and **	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits									
	danyl feho					1 ¼ Yes 2 ☐ No									
	vith the Mar	MD Frederick Emmitsburg 10e. Street and Number 10f. Zip	Code	10	g. Citizen of What	Country?									
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	r items 23a	335 South Seton Avenue 2 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	1727 dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,									
(0	r Rer	Armed Forces? If Yes, spect 1 ☑ Never Married 2 ☑ Married 1 ☑ Yes 2 ☒ No		Rican, etc.)	Black, W	hite, etc.									
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21215-0036	ed within 72 hours ygiana. ver than "natural", it, to Medical Exi	15. Decedent's Education 16a. Decedent's Usua (Specify only highest grade completed) (Give kind of wo.	al Occupation	ing 10	6b. Kind of Busine										
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nd	Tage H	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Sumame)										
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Maryland	2 2 2		(Street and Number or Run			e, Zip Code)									
	a 2 a		Seton Avenue,			21727									
9	gas 1 t of Ha If Itan or oth	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ther place)	Date 20	Oc. Location - City	or rown, State									
Baltimore,	parmit. Pagas of Papartmant of Himportant: If its any injury or of price.	4 Donation 5 Other (Specify) ST. JOSEPH'S		24/2007	EMMITSBUI	RG, MD.									
Sal	Dapar Dapar Impor any in	21. Signature of Funeral Service Licensee 22. Name an	nd Address of Facility	KILES FUN	ERAL HOM	E									
	20260		MAIN ST., EN		·										
		23a. Part Enter the disease, or complications that caused the death. Do not enter the mod shook, or heart failure. List only one cause on each line.	le of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between									
	Physician	mmediate Cause (Final													
	/Medical Examiner	disease or condition resulting in death)	Hemar	mage		1 ween									
		↑ Due to (o <sub>h</sub> as a consequence of)		0		11.1									
SI	axecuted in and ital-transit	Sequentially list conditions  Due to (or as a consequence of):	Vigu.	1		100									
, h	axecu n and ial-tre	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	FA	U,		11.1									
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Вох	attanding for usa as	d													
	daatt a atta ad for	Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributions.	ause given in Part I.	23b. Did tob	acco use contrib	ute to the cause of death?									
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/ita	Physician: T this cartifical ral diractor, p	25. Was case referred to medical examiner?		h (Check only one	)										
=	\$ 0 D	The state of the s	11	me 5 Residen		pecify)									
	Ing P	27. Manner of Death 28a. Date of Injury 28b. Time of 1 Natural 5 Pending (Month, Day Year) 22b. Time of 1 Injury	Work?	28d. Describe hov	injury occurred										
Sio	tend Jaath tor: / tha f	2 Accident investigation 3 Suicide 6 Could not be	1 ☐ Yes 2 ☐ No	20f Location (Str	not and Number of	Rural Route Number,									
Division	tal or Attending P rs after death. si Director: After t ied in by the funers Certification.	4 Homicide determined 28e. Place of fnjury - At home, farm, street, factory building, etc. (Specify)	y, onice	City or Town,	State)	ribrarrioble rumber,									
_			at the time, date and place	and due to the car	ise(s) and manner	as stated.									
	in 24 hours in 24 hours he Funer plataly fil	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.													
	Nithin Fo the Compl		c. License number		d. Date signed (Me	onth, Day, Year)									
)	->-0	De Company	D1870	5	MAY 21,	2007									
7	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
	1	ALAN CARROLL, M.D., 310 S. SETON AVE., EM	MITSBURG, MD.	21727											
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature													
	Registrar	MAY 2 A 7007 Library La 1980													

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 28 200<del>7</del> 8:35A SMITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRADFORD OAKS NURSING HOME CLINTON PRINCE GEORGES 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign Months 1□M 2XF 89 577-19-9067 Yrs Director 17,1917 SOUTH Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director PRINCE GEORGES 1X☐Yes 2☐No FT. WASHINGTON MD the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3613 COPPERVILLE WAY 20744 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ₹ ₹ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. iit. Pages 1 and 2 should be filed within 72 hours after riment of Health and Mental Hygiene. rtant: If Item 27 Ie marked other then "natural", or ite njury or other traumatic event, The Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: þ Specify: BLACK 3X Widowed 4 ☐ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) FASHION DESIGN DRESSMAKER 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 EBENEZER AZORE PRINCESS HOPE 19a. Informant's Name/Relationship (Type, Print) DAUGHT P9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3613 COPPERVILLE WY. FT. WASHINGTON, MD GABRIELLE SMITH-BARROW/ 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Daurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEM. 5-5-07 CLINTON, MD permit.
Deports
Imports
eny nju 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service Licensee Ott Wart Keny 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CHOLANGIO CARCINOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Dira to (or as a consequence of): Examine anding physicien and use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Day Month Year 1 ☐ Yes 2 ☐ 💢 o 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 1 ☐ Yes 2 ☐ No : After this certifical tuneral director, I Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) ۵ 4 | Homicide determined filled in 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035206 Ourely May 1,2007 Lin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM TANNER, MD 11701 LIVINGSTON RD. FT. WASHINGTON, MD 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY O 9 2007 Registrar

		4	For State Registrar	State of Ma	-	epartment of H Certificate of L			ene	17	6951	
			Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	n Day	Year	3. Time of Death	٦
	Physicia /Medic		James H.	Shirl	ey, Sr.			May 3, 2	2007		9:35 A M	
	Examin		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or	Location of Death		4c. County	of Death		
			29990 Holmes Roa	d			nicsville			Mary's		_
	Funeral			Sex 7. Age 1. Mg 2. □ F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		ce (State or Foreign	
	Director		579-18-4650	TQLWI ZUT	85 Yr	S.		July 8,	1921	Virgi	nia	-
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				100	I. Inside City Limits	
	Mary	ō	Maryland St. Man	77.1	Mechani	csville					1 X Yes 2 ☐ No	
	28a	Director	10e. Street and Number	. у Б	neenanz	10f. Zip Code		10	Og. Citizen of V	What Country	y?	
	3a or		29990 Holmes Ro	ad		20659			U.S.A.			
	ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	spanic Origin? (Sp	ecify Yes or No-	14. Rac	e - American		_
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23e or 28a-f show other traumatic event, the Medical Examinar must be rediffed at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 N  If Yes, Give  Year or Dates:	0	1 ☐ Yes 2 No	Specify:	nican, etc.)	Specify			
ŏ	2 hou	bed	15. Decedent's E		16a. D	ecedent's Usual Occup	ation	ina	16b. Kind of Bi	usiness/Indu	stry	П
215	nin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)  College (1-4or 5-	1	Give kind of work done of ife. DO NOT use retired	) )	ing .	James 1			
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yla	Ment Ment arked	2	Ernest Latimar					Mae Harr				
lan	and and in ma	. 1	19a. Informant's Name/Relationship	(Type, Print)	19b. M	Mailing Address (Street	and Number or Rui	al Route Number,	City or Town,	State, Zip C	code)	ì
	es 1 and 2 of Health of fitem 27 is r other tra		Charles W. Shirle	ey - Son		46 Wilson Disposition (Name of	Road, Mec	hanicsvi	11e, Ma	arylan	d 20659	-
Ore	ges 1 t of H if ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [	Removal from State	cemetery,	crematory or other place	θ)			,		
Ë	Pa tmen tant:		4 Donation 5 Other (Spec		Fort L:	incoln Ceme		9/2007 I			aryland	-
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot		21. Signature of Funeral Service Lice	7 4	1	22. Name and Address Gasch's Fu	- 1	10 P A			ore Ave.	J
_	42204		23a. Part1. Enter the disease, or cor							1	Approximate	-
		9	shock, or heart failure. List only Immediate Cause (Final	y one cause on each in	3		<b>3.</b>	,			nterval Between Onset and Death	
	Physician /Medical	1 1	disease or condition resulting in death)		neym consequence of					>	2 week	=
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ó	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a	consequen of	):	-0 - 1	Caile	$\neg$	7	142	
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9	ing p	Med	IF FEMALE:									
Вох	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal death	3 Ectopic pregnancy				ite of delivery onth D	/ Day Year	
0.	he de the g	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	lime of death	5 Other (specify)						
Δ.	that the ded by the detached		Part II. Other significent conditions	contributing to death bu	It not resulting in	the underlying cause giv	en in Part I.	23e. Did tot	oacco use con	tribute of the	cause of death?	
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Re	The lay	Completed						autops	med3	prior to com death? 1 \( \text{Yes} \) 2	pletion of cause of	
la		ပိ	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 th (Check only on		10 105 2	:	
	Physician: r this certific ral director.	OB	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3 DOA Ott	00	ome 5 Neside		ner (Specify)		
ō	Phy erat c	-	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Ti		y at	28d. Describe ho				-
ion	Attending in death.	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigati		7 927) 111]		Yes 2 □No					
Division	oi or Attending F s after death. i Director: After d in by the funera	Certification:	3 Suicide 6 Could not			m, street, factory, office		28f. Location (Si City or Town	treet and Numi	ber or Rural	Route Number,	
Ö	tel or A rs after al Direction	Cer										_
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in the	Medical		Physician: To the best of eminer: On the basis of and manner sta	examination and							
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signe	ed (Month, D	ley, Year)	
			· /	uli		000	62213	>	5 3	1 1		
2	(10)		30. Name and address of person who Dr. Patel, 22	o completed cause of d			town MD					
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature,	le, Leonard	COWIL TID					-
	Regist	rar	MAY 0 9 2007	May w D	. Would	Ma.						

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	·	For State Registrar		State o	f Maryl		epartment of F Certificate of		d Mental H	ygiene Reg. No.?	0.7	16952
Physicia /Medic	_	Decedent's Name (First,     The 1ma					Shapiro		2. Date of D Month May 7	Day 2007	Year	3. Time of Death 3:00 P M
Examin	er	4a. Facility Name (If not insi Brighton Gar				ing	4b. City, Town, c	11e		Mont	unty of Deatl	
Funeral Director		5. Social Security Number  579-10-6151  Usual Residence of Decede		]M 2∭∑F	7. Age (In )	yrs. last birth	Months   Days			Day, Yea <i>r</i> )		nplace (State or Foreign untry) shington DC
1-f show	tor	10a. State 10b. C		ry		City, Town o						10d. Inside City Limits 1
3a or 28s	al Director	10e. Street and Number 5550 Tuckerm	an Lan	e #519			10f. Zip Code 20852				of What Co	
al", o	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div	] Married	12. Was Dece Armed Fo 1 ☐ Yes if Yes, Giv Year or D	orces? 2 <b>X</b> No ve	in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√ No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)		Race - Amer Black, White pecify:	
giene. rr than "natur the Medical	Completed	15. Dec (Specify only) Elementary/Secondary (0		cation completed) College (1	1-4or 5+)	9	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire emaker	oation during most of d)	working		of Business/I	Industry
Mental Hy arked othe atic event,	To Be (	17. Father's Name (First, M Louis Whall	iddle, Last)						Name (First, Middl Leah Need		rname)	
alth and		19a. Informant's Name/Relaction Stephen M. S'		·	L	- 1	Mailing Address <i>(Street</i> 8 Woodland					
not: If item		20a. Method of Disposition 1 ▼Burial 2 □ Crema 4 □ Donation 5 □ Ott	ation 3 R	emoval from	State K	b. Place of D cemetery, ing Da	isposition (Name of crematory or other pla vid Memori Gardens	al 5/	Date 9/07		ion - City or	Town, State
Departn Departn Importa any Inju		21. Signature of Funeral Se	ervice License				22. Name and Addre Edward Sa 1091 Rock	ess of Facility		-		
hysician /Medical xaminer e priiritiansil	Examiner	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to Hyp	diac (or as a con erosc (or as a con erten	Arrest sequence of leroti	: c Heart Di		rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, it	Certification:	2 ☐ Accident ir 3 ☐ Suicide 6 ☐ C	Pending nvestigation Could not be letermined	(Mon 28e. Place	th, Day Yea	r) Inju	iry Wo	ryat rk?  Yes 2∐No	28f. Location	(Street and Nown, State)		ral Route Number,
n 24 hours he Funera pletely fille	Medical C	29a. Certifier 1 XCe (Check only 2 Me	rtifying Phys dical Examí	ner: On the b	e best of my asis of exar ner stated.	knowledge, onination and/	death occurred at the ti or investigation, in my	me, date and p opinion, death	place, and due to the	e cause(s) and e, date and pla	d manner as ace, and due	stated. to the cause(s)
	Ň	•	artifier 1	ref	2			3691		29d. Date si		n, Day, Year)
		30. Name and address of Ajay Reddy M					<sup>(pe, Print)</sup> Bethesda M	D 20817				
Sta Registra		31. Date filed (Month, Day,	10 20	4	egistrar's S		Coaste					

			For State Registrar	State o	of Marylai	nd / Dep <i>Ce</i>	artmen rtificate	t of H e of L	ealth a Death	and M	lental Hy	giene Reg. No	Break Yolf Turi	To any	1695:
I	Physic		Decedent's Name (First, Middle,     Ursula	Last) Shepheard	1						2. Date of De. Month May 2,	ath	, Va	ar	3. Time of Death 2:30pm M
	/Medi Examir		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death		1	County of D	eath	
			Manor Care Che	vy Chase			Che	evy (	Chase			Mo	ntgom	ery	
	Funeral Director		578-64-5912	5. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 91	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da June 15	h y, Year) , 191	9. .5 E	Birthpl Count ng1	ace (State or Foreign ny) and
	and *	1	Usual Residence of Decedent  10a. State 10b. County		100 0	ity, Town or Lo	acation							10	d. Inside City Limits
	Aaryli eho	5	MD Montg	omery		hevy Cl								10	1. Inside City Limits 1. Yes 2 □ No
	288-	Director	10e. Street and Number	-			10f. Zip	Code				10a Citi	zen of What	Count	
	3a or	0	8700 Jones Mil	1 Rd				)815					ted S		•
	death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.			spanic Ori	gin? (Spe	acify Yes or No Rican, etc.)		14. Race - A	merica	n Indian,
0	or Ita	Ē	1 X Never Married 2 ☐ Marrie		2 X No					i, Puerto	Rican, etc.)		Black, W	/hite, e	tc.
3	ours	d by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ates:		1 ☐ Yes 🔀	LIZI NO	Specify:				Specify:	Whi	te
CDD-C12	natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usua kind of wor	k done a	uring most	t of worki	ing	16b. Ki	nd of Busine	ss/Ind	ustry
V	withir then then	E d	Elementary/Secondary (0-12)	College (	1-4or 5+)		<i>DO NOTu</i> s nstrat					17.	11 D-	1	
N 5	Hygie ther ther		17. Father's Name (First, Middle, L	<u> </u>		Admil	istrat	ive			(First, Middle,		1d Ba	nĸ	
2	d be ental	To Be	Thomas F. Sheph	•				İ			ne E. C		,		
	Shoul nd Mo mari	-	19a. Informant's Name/Relationshi			19b. Maili	na Address	(Street a			Il Route Numbe			e Zin (	Codel
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or itams 23a or 28a-f ehow important: If Item 27 is marked other then "natural", or itams 23a or 28a-f ehow any fourty or other traumatic event, the Medical Examinar must be neithed at ODGs.		Frank Fenwick /	Attorney	7						e,N.W.				
נֿע	of Her		20a. Method of Disposition	_		Place of Dispo cemetery, crei	osition (Nam	e of	a)	C	ate	20c. Lo	cation - City	or Tow	n, State
aitiiio	Page Int: If		1 ☐ Burial 2 ☑ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		State	ational				5-10	<b>-</b> 07	Fall	s Chu	rch	,VA
2	Departition Departments imports eny inju		21. Signature of Funeral Service Li	censee							eph Gaw				
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	Cate be executed by Medical Examiner but street by the parial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyj	rdiac A (or as a consecutor as	iuria juence of):	ia								Onset and Death
3	ntifica ng ph s as th	Med	IF FEMALE:												
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours elfer death. within 24 hours elfer death. to the Funeral Director: After this certificate has been signed by the eltending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ∏ Feta ant at time of o	ıl death 3 [	Ectopic pre Other (spe					2	3d. Date of Month		/ Pay Year
,	quires tha en signed I uld be det	þ	Part II. Other significant condition Failure To Thir	s contributing to de	eath but not res	ulting in the u	nderlying ca	use give	n in Part I.						cause of death?
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	The Ite has bage	E									autop perfor	med? 20 No	prior death	?	Dietion of cause of
3	ien: rrtifice ctor. p	BeC	25. Was case referred to medical examiner?	1					26. Place	of Death	Check only or		'''		T 140
	hysic his ce I dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 □ I	npatient 2	ER/Outpatien	t 3□ DO	Othe	r: 4 🙀 Nur	rsing Hon	ne 5 Resid	ence 6	Other (S	pecify)	
	*Attending Physicien: The lav ar death. *ector: After this certificate has by the funeral director, page 2		27. Manner of Death  1 Matural 5 Pending 2 Accident investiga	tion	of Injury h, Day Year)	28b. Time of Injury	M 28	Ic. Injury Work 1 🗆 Y	at ? es 2 □ N		28d. Describe h	ow injury	occurred		
	tal or Att s efter de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place buildir	of Injury - At he ng, etc. (Specif	ome, farm, str	eet, factory,	office		2	28f. Location (S City or Tow	treet and n, State)	d Number or	Rural	Route Number,
	To the Hospital or Attending Physimitin 24 hours eiter death, within 24 hours eiter death, To the Funeral Director: After this completely filled in by the funeral director	Medical	one)	Physician: To the aminer: On the ba and mann	asis of examina	wludga daath tion and/or inv	estigation,	t the time in my opi	e, date and inion, deat	d place, a h occurre	rid due to the e ed at the time, o	aus.(s) ate and	and mannot place, and c	as stat	ed. ne cause(s)
	ToT	Σ	29b. Signature and title of certifier		Ti	1) .	29c.	License	number				signed (Mo		ay, Year)
	6		- Ramar	1	100	L1		19	60	9		5.	9.07		
			30. Name and address of person was Raman R. Tuli	, M.D. 3	e of death (Item 503 Per	ry St	∦B¹, Mt	. Ra	nier,	MD					
	Sta		31. Date filed (Month, Day, Year)		istrar's Signa	ture	1 d								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician ROBERT SCHAFFER 8, 2007 MAY 12:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY CASEY HOUSE ROCKVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MARCH 8, 1920 Months Days 1**X**M 2□ F Hours NEW YORK 123-12-8270 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show notified at SILVER SPRING **MARYLAND** MONTGOMERY 1 XYes 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or must be 15101 INTERLACHEN DRIVE, # 314 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after dinportant: of Heath and Mental Hyglene. Important: if Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 XYes 2 No ARMY
If Yes, Give
Year or Dates 944—1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U. S. GOVERNMENT 5+ CHEMIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYMAN SCHAFFER ESTHER MINSK ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) 15101 INTERLACHEN DRIVE, # 314, SILVER SPRING, MD EDITH P. SCHAFFER - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriał 2 ☐ Kremation 3 ☐ Kemoval from State ALEXANDRIA, VIRGINIA 5/9/07 METROPLOLITAN CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD. 20852 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician Blast Crisis** /Medical Due to (or as a consequence of) Examiner Chronic Neutrophibic Leukemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Polycythemia Vera burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) H<del>ouse</del> Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ the Funeral Director: After the appletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funeral 29a Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0058637 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Cynthia M. Williams, D. O. Montgomery Hospice Rockville, Maryland 20855 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 23a per phy State of Maryland / Department of Health and Mental Hygiene aaco hith degt state 05/08/07 diw Certificate of Death OF Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician BRADY AMES 200 ()L /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 207 St. Andrews Road Anne Arundel Severna Park 8. Date of Birth (Month, Day, Year) Mar. 13, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1916 Director 91 213-14-4796 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location works 10d. Inside City Limits ms 23a or 28a-f shov must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 St. Andrews Road 21146 USA Funeral death items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. be filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married WWII ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. ģ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Family Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Medicine Physician 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Edward Smith Lillian Brady Pages 1 and 2 should ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Lee Smith/Wife 207 St. Andrews Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 2 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 20Ò7 22. Name and Address of Facility P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the death certificate as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 nknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2**X** No ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 □Other (Specify) 27. Manner of Death 1 ANatural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury e Hospital or At.
hours after death.
n Director: A\* 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number Chief Medical Officer 29d. Date signed (Month. Dav. Year) Hospice of the Chesapeake

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401 MAY 0 8 200 trar's Signature 31. Date filed (Month

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Physici Medical Exam	an/	1- For State Registrar mend #5 Per FH C 1. Decedent's Name (First, Middle, Last MATTHEW CLARK		<u> </u>	cate of Deal	uri		2. Date of Death Month April 29, 20	Day Year	3. Time of Death 2140 hrs		
•		4a. Facility Name (if not institution, give 535 Union Church Road			4b. City,		Location of Deat		4c. County of De Cecil	ath		
Funeral Director			7. Age (I	In yrs. last bi 24		der 1 Yea hs Days		_	1982 For	Birthplace (State or eign Country) DE		
yland •-f show any <u>once.</u>	tor	Usual Residence of Decedent		,.	n or Location LETOWN	p Code		Lai		10d. Inside City Limits 1 X Yes 2 No		
eath with the Maryland items 23a or 28a-f show ust be notified at once.	al Director	117 BOXWOOD RD	10.34	:-11.0	19	709			10g. Citizen of What Country? USA			
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menal Hygiewile Inperaint of Health and Menal Hygiewile Imperaint. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		12. Was Decedent Even Armed Forces?  1 Yes 2 If Yes, Give Year or Dates:	No	If Yes, spec	ify Cuban	, Mexican, Puert specify:		White, etc	WHITE		
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1215-0 d be filed w fental Hygic narked othe	o Be Co	17. Father's Name (First, Middle, Last)  MICHAEL C SHEA  19a. Informant's Name/Relationship (Ty		La	Oh Mailian Addus		SANDRA		CECIL			
e, MD 2 and 2 shoul Health and N item 27 is m traumatic	Ţ	SANDRA SHEATS / 20a. Method of Disposition		20b. Place	117 BOXW	OOD I	RD MIDE		ber, City or Town, Standard DE 19709  20c. Location - City			
altimora mit. Pages 1 partment of 1 portant: If ury or other		1 Burial 2 XX Cremation 3XX Removal from State crematory or other place) 4 Donation 5 Other Specify: MAYERDALE CREMATORY MAY 4, 2007 NEWARK  21. Signature of Funeral Service Licensee 22. Name and Address of Facility SPICER—MULLIKIN FUN										
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To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:	n: To the best of my kr On the basis of examinand manner stated.		investigation, in m	y opinion	, death occurred		and place, and due to	the cause(s)		
	2	29b. Signature and title of certifier	1m	h (ltc= 33 )		O.C.			29d. Date signed (#April 30, 2007	Month, Day,Year)		
3			tant Medical Exar	miner 1	I11 Penn Stree	et, Balt	imore, MD 2	1201				
St Regis		31. Date filed (Month, Day, Year)	32. Negistrar's	Signature	boorte							

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	4			on, give street and nu	mber)	4b. City Berl	, Town, or Location of	Death		Worceste	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Extended.	٩			nship (Type, Print)	MOTHER	12518	WYE LANDIN	G LANE,	WYE 1	IILLS,	MD 21679
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the H hin 24 the Fo	Medical	(Check only one) 2	✓ Medical	Examiner:On the ba	sis of examination	n and/or investigation	, in my opinion, death	occurred at the th	me, date a	no piacoj am	
To To Suit.	Me	29b. Signature	and title of ce		1	/	29c. License numb	er			gned (Month, Day, Year)
	1	1	chi	WY	1	>	O.C.M.E.			May 19, 2	
1.				rson who completed	cause of death (It	em 23a)	Street, Baltimore	MD 21201			
<b>1</b> 0	1		n Ali, M.D.		edical Examin	er 111 Penn	otreet, Baitimore	, IVID 2 120 I			
P		1			Desirtante Ci-	ature					
	Stat	e 31. Date filed (			Registrar's Sign	nature	,				

	1 State	State of Maryla				lental Hy	/giene	63 64 ES 64	
-	Registrar			ertificate of	Death		Reg. No.	2007	155
n	Decedent's Name (First, Middle, La.					2. Date of De Month	eath Day	Year	3. Time of Dea
ıl	Richard L. Thoma			T # 0" =		May	7	2007	10:10
r	4a. Facility Name (If not institution, give	,			r Location of Death			County of Death	
-	Southern Marylar  5. Social Security Number 6. S		rs. last birthda	Clinto		8. Date of Bi		ince Ge	orge's  nplace (State or For
		1 🔯 M 2 🗆 F	66 Yrs.	Months Days	Hours Min.	(Month, Di 9/26/1	ay, Year)	Cot	intry)
	Usual Residence of Decedent					_9/20/.	1940	wasn	ington, I
_	10a. State 10b. County	10c. 0	City, Town or	Location					10d. Inside City Lir
Director	Maryland Prince G	George's For	rt Wash	ington					¹x Yes 2□
2	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	untry?
Funeral	9501 Caltor Lan				744		USA		
ņ	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	<ol> <li>Race - Amer Black, White</li> </ol>	
Dy.	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify:	B1ack
- C	15. Decedent's Ed		16a, Dec	edent's Usual Occup	pation		16h Kir	nd of Business/l	ndustry
per	(Specify only highest gra	ade completed)	ı (Gir	ve kind of work done . DO NOT use retire	during most of work	ing			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Speci	lal Police	Officer		Fede	ral Gov	ernment
De Re	17. Father's Name (First, Middle, Last)	)			18. Mother's Name	→ (First, Middle			
0	Richard L. Thomas	s, Sr.			Dorot	hv Sava	906		
	19a. Informant's Name/Relationship (	**	19b. Ma	iling Address (Street	and Number or Run			r Town, State, Z	ip Code)
	Sherril Thomas/Wi	fe	Fort	Caltor L Washingt	ane on, MD 2	0744			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		. Place of Dis	position (Name of rematory or other pla	1 1	Date	20c. Lo	cation - City or T	owп, State
	4 □ Donation 5 □ Other (Specif	fy) Fo	ort Lin	coln Ceme	tery 5/10	/2007	Bren	twood, 1	MD
	21. Signature of Funeral Service Licer	nsee M 0 //	7	22. Name and Addre	ss of Facility For	t Linco	oln F	uneral	Home
	Mah	Much		8401 Blade					20722
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	. End stac	Meta	atatic dia	an of	lune			Onset and Death
	resulting in death)	a. End stay Due to (or as a creat b. Pup Vin	equence of):	,,,,,		0			J. 17-7-01
	Sequentially list conditions,	b. Dup va	ous t	homboil					47 Knon
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (of as a conse	equence of):						
(all	that initiated events resulting in death) Last	C							
_	Tooling it doubly Edet	Due to (or as a conse	equence ot):						
, in									
<u> </u>		_d			-				
Medic	IF FEMALE:				****				
ian/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg	etal death 3	B⊟Ectopic pregnanc	y		2	3d. Date of deliv	•
ysician/imedic	23b. Was decedent pregnant	23c. If yes, outcome pf preg	etal death 3	□Ectopic pregnanc	у		2	3d. Date of deliv	very Day Year
Pnysician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 of death 5	Other (specify)	·	23e Did		Month	Day Year
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			For State Registrar		State o	of Marylar		artmen tificate			and M	•	giene Reg. No.	007	155	)59
			Decedent's Name (First,	Middle, Last)								2. Date of Da. Month	ath	Year	3. Time o	of Death
	Physici /Medio		Mary Randolp	h Weis	iger							May 9,	2007	, , , , , , , , , , , , , , , , , , , ,	0713	АМ
Tribe.	Examin		4a. Facility Name (If not inst Kline Hospic			mber)	i	Mt.	Airy	Location o	f Death			ounty of Dea derick		
	Funeral Director		5. Social Security Number 262–20–6290		( ]М 2 <mark>X</mark> F	7. Age (In yrs.	last birthday) 86 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da June I	y Year 19	9. Bin 20 Mis	hplace (State ountry) SOUTI	or Foreign
	and		Usual Residence of Deceder 10a. State 10b. C			10c. Ci	ty, Town or Lo	cation							10d. Inside 0	City Limits
	Maryl f sho	tor	MD Fre	derick		Fred	lerick									s 2 🗆 No
	r 288	Director	10e. Street and Number	uci ici				10f. Zip	Code				10g. Citize	en of What Co	ountry?	
	th wit		537 Carrollt	on Dri	ve			217	01				USA			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "netural", or Items 23s or 28e-f show eumatic event, the Medical Ever, it art mast be multified at	by Funeral	11. Marital Status 1 X Never Married 2 □	] Married	Armed Fo	2 □ No		Was Deced Yes, spec		spanic Orig , Mexican Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)		I. Race - Ame Black, Whit Specify: Wh:	e, etc.	
Ş	tural'	q pa	3 Widowed 4 Div	orced cedent's Edu		Dates: 1942	-40   16a. Deced	lent's Heur	I Occupa	tion		1		of Business		
Ċ	in 72 n "ne	Completed	(Specify only	highest grade	e completed)	4.45.	(Give	kind of wor OO NOT us	rk done di se retired)	uring most	of worki	ng	IOD. NING	of Business	industry	
212	d with	mo	Elementary/Secondary (0	1-12)	College ( 5+	1-40r 5+)	Interi	or De	ecora	ator			Inte	rior De	ecorati	.on
9	al Hyg	3e	17. Father's Name (First, M									(First, Middle,		umame)		
<u>X</u>	should bind Ment	To	Cary Nelson W									se Litt				
, Maryland 21215-0036	is 1 and 2 should of Health and Men item 27 is marke other treumatic		19a. Informant's Name/Rela Louise W. Per				1003 \	icksl	ourg	Plac.	r or Rura e At	l Route Numbe lanta,	GA 30	Town, State, 2 0350	Zip Code)	
Baltimore,	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Disposition  1   Burial 2   Crema	ation 3 □R	emoval from	State 20b.	Place of Dispo cemetery, cren	sition (Nam natory or of	ne of ther place	)		ate		ation - City or		
	t. Pa rtmen rtent:		`4 □ Donation 5 □ Oth	ner (Specify)		Ch	esapeal			- 1				sville		
g	permit. Pages 1 Department of H Importent: If itel any Injury or ott		21. Signature of Funeral Se	f	Let		1251 Be	verly	y L.	Heck	rott	n Servi e, P.A.	Claı		Le, MD	
	Priysician /Medical Examiner		23a. Parl 1. Enter the disas shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	. List only or	ne cause on e	or as a consec	(19)	_	n CP	, such as	cargiac o	r respiratory ar	rest,		Approxima Interval Be Onset and	tween
, 00,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated svents resulting in death) Last	1	·	(or as a conseq										
9/8	physic	dical			l											
O. BOX 6	ath certifi ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months: 1 □ Yes 2 ☑ No 9 □ Unknown	rit	1☐Live b	tcome of pregna birth 2 Peta nant at time of co	ıl death 3 ☐	Ectopic pre Other (spe					23	d. Date of del Month		Year
ras, r	gned b	by	Part II. Other significant co	nditions con	tributing to d	U	sulting in the ur		ause give	n in Part I.		23e. Did to			the cause of obably 4	death?  Unknown
Hecord	e law has b	ompleted	J -									24a. Was autop		prior to death?	topsy findings completion of c	available cause of
VITAI	sicien: Th certificate rector, pag	Bec	25. Was case referred to m examiner?	edical						26. Place	of Death	(Check only o				
0 10	y s	2	1 ☐ Yes 2X No	Н	_		ER/Outpatien		-	4 LI NUI		ne 5 🗆 Resid			cify) hosp:	ice
	tending Ph leath. tor: After th the funeral	iuo.		ending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		Bc. Injury Work			8d. Describe h	ow injury o	occurred		
UNISION	fter of pirec	Certificati	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place buildi	of Injury - At hing, etc. (Specif	ome, farm, stre	M et, factory,		es 2□N		8f. Location (S City or Tow		Number or Ru	ıral Route Nun	nber,
_	spite hours nerel y filled	edical Ce	29a, Certifier 1 XCer (Check only 2 Merone)	rtifying Phys dical Examir	er: On the b	best of my kno asis of examina ner stated.	wledge, death	occurred a	at the time in my opi	e, date and	d place, a	nd due to the o	cause(s) ar	nd manner as lace, and due	stated. to the cause(	s)
	To the Ho within 24 I To the Fu completely	Med	29b. Signature and title of c	ertifier	and man	Troi statou.		29c.	License	number			29d. Date :	signed (Monti	n, Day, Year)	
9	FSFO		bart	118		1 64	-1	2	15	164	2		May	10, 20	07	
10	541		30. fpe	erson who co	mpleted caus	se of death (Item	n 23a) (Type,	Print)	- 7	60' -	10	mb	di	702		
	Sta Registr		31. Date filed (Month, Day,	1 1 20	107 32.9	igistrar's Signa	iture	reck	0	× 7 0	43_		27			

			For State Registrer	State of	Marylar	nd / Depa		t of H	ealth a		ental Hyg		007	16960
1	Physici	an	1. Decedent's Name (First, Midd	le, Last)						1	2. Date of Dea Month	h Day	Year	3. Time of Death
. 1	/Medio	al	Patricia Sue  4a. Facility Name (If not institution		a hast		4h City	Tour or	Location of		May	5,	2007 ounty of Death	3:20 a <sup>M</sup>
	Examin	er	1069 Little M	*			4b. City,		apoli				nne Ari	undel
	Funeral Director		5. Social Security Number 577–46–9500	6. Sex 1 □ M 2√2 F	7. Age (In yrs. <b>7</b> 3	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min. J	B. Date of Birth (Month, Day) uly 29	Υθα <i>τ)</i> 193	9. Birthi Coul Wash	place (State or Foreign http) ington, D.C.
-1/2	land		Usual Residence of Decedent  10a. State 10b. County	1	10c. Ci	ty, Town or Lo	ocation	-						10d. Inside City Limits
	Mary Pe-f sh	tor	MD Anne	Arundel		Annaj	polis							1 ☐ Yes 2 🙀 No
	or 28	Direc	10e. Street and Number				10f. Zip				1	0g. Citizer	n of What Coul	ntry?
	eath w	eral	1069 Little M	lagothy Vie		6 12	Mas Deced		409	ain? (Saos	fy Voc or No.	14	USA Race · Americ	can Indian
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or iteme 23a or 28e-f show event. I've Medical Evarifical must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Mai  3 Widowed 4 Divorce	ned 1 ☐ Yes	ces? 2 <b>∑</b> No e		was Deced If Yes, spec 1 ☐ Yes 2		n, Mexican	n, Puerto R	rfy Yes or No- ican, etc.)		Black, White, pecify: Whi	etc.
21215-0036	72 ho	eted	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usua kind of wor	al Occupa	ation during mos	t of working	2	16b. Kind	of Business/In	dustry
121	within 72 ane. than "nat	mpl	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	e retired, emake	)				Home	2
9	filed v Hygie other t		9 17. Father's Name (First, Middle	Last)			ПОШ	ellak		r's Name (	First, Middle, I	Maiden Su		=
lan		To Be	Elsie Portmar	McGahan						Margu	reite A	Adams		
, Maryland	nd 2 stith artit		19a. Informant's Name/Relation John J. Wilson				ng Address <b>9 Litt</b>				Route Number .ew Ant	_	iown, State, Zip	
o o	Pages 1 ar nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		State	Place of Disponentery, cres			θ)	May 2007	10		tion - City or To Ltimore	
Balt	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service	Barri	,	8 49	arrand 95 Gov	d Addres CO & V. R.	Sons Sons itchi	P.A e Hwy	. Seve	erna erna	Park Fu Park, N	neral Home D 21146
,09/	Cate be executed which is the burial-transit supering the	dical Examiner	23a. Party Enter the disease, cashock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ach line.	QUENCE of):								Approximate Interval Between Onset and Death
	death certif e ettending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		rth 2 ☐ Feta ant at time of c	ıl death 3□	Ectopic pro					230	d. Date of delive Month	ery Day Year
rds, P	as tha	þ	Part II. Other significant conditi	ons contributing to de	ath but not res	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did tot			he cause of death?
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Vita	Physician: rthis certific ral director,	Be (	25. Was case referred to medica examiner?							of Death (	Check only on			
ō	ding Phy h. After this funeral d	tlon: To	1 Yes 2 No  27. Manner of Death 1. Natural 5 Pendi 2 Accident invest	28a. Date o		28b. Time of Injury		8c. Injury Work	4 U Nu	28	e 5 Reside			(y)
5	el or Attending s after death. Il Director: Afte id in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of tnjury - At h	ome, farm, str fy)	eet, factory	, office		28	of Location (St City or Town		lumber or Rura	al Route Number,
:	To the Hospitel or Atterviewithin 24 hours after de To the Funerel Directs completely filled in by the	Medical C	29a. Certifier (Check only one) Certifyi	ng Physician: To the Examiner: On the ba and mann	sis of examina	owledge, death ation and/or in	h occurred a vestigation,	at the tim in my op	ie, date an pinion, dea	d place, an	d due to the ca	ause(s) an	d manner as s ace, and due to	stated. the cause(s)
	To the within 2 To the complet	×	29b. Signature and title a certific	Um				. License		,	2	9d. Date s	igned (Month,	Day, Year)
	المار	7						37	064			SL	7107	
	D/M		30 Name and addr. ss of person	·	_		Print)	, -	n	$Q_{2}$	210	2		
	Sta Registr	_	31. Date filed Month Day Year	8 2007 32.	istrar's Signa		park		/	יע	210	ا <u>د</u>		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Williams 945 /Medical 08 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 54/1564/4 Moonico Social Security Number 6. Sex Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 213-22-7579 Months Days Hours Min 1 □ M 2 X F Director 5/17/1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 □Yes 2 No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7545 Levin Dashiell Rd. Funeral 21830 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify. þ Specity 3X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other that any injury or other traumatic event, the any injury or other traumatic event, the ones. 12 Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger Brooke Troy 2 Laura Beatty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert T. williams/son 7577 Levin Dashiell Rd., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory 4 Donation 5 Dother (Specify) 5/12/07 Hebron, MD Gardens 21. Signature of Funeral Service Lice <sup>22, Name and Address of Facility</sup> Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Call 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 7923 UN /Medical Due to (or as a consequence of): Examiner 0 ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. attending physician for use as the buria signed by the a d be detached f certificate has

the Maryland

within 72 hours after

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Baltimore, Maryland 21215-0036

sician and burial-trans the funeral director, page 2 should this After within 24 hours after death To the Funeral Director: filled in by

Certification: To

Medical

	Acris ,	Belmonoy	Emboli:	<u> </u>	1 Yes 2 No 3 Probably 4 Monknown
_	(Asin	Rel/F	allen.		24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No
25. Was case refer examiner?	red to medical			26. Place of De	ath (Check only one)
1 ☐ Yes 2☐	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ □	OOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	h 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only	1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	owledge, death occurre	d at the time, date and place	e, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

and manner stated.

aw

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mont) 32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

completely

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32. Registrar's Signature

Musa St. Sut 301,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/8

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

# Charles young CTBC 124 5-7-2007 Baltimore, Maryland 21215-0036

Box 68760,
P.O.
Records,
Vital
Division of

		For	State of Marylan	d / Depa	artmen	of Health and	•		gible.	16963
		1 - State Registrar		Ce	rtificate	e of Death		leg. No.		10300
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/Medic		Charles Her	ry Young				May 7,	2007		12:45 Ma
Examin	er	4a. Facility Name (If not institution, give				Town, or Location of Dea	th		nty of Death	
		MANOKIN MANOR NU				INCESS ANNE			MERSET	
Funeral		5. Social Security Number 6. S	KIM 2DF	last birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs Days Hours Min		Year)	9. Birthpl Count	ace (State or Foreign try)
Director	-	081-07-6100 Usual Residence of Decedent	104				5/3/19	903	New	York
land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation			<del>.</del>	10	d. Inside City Limits
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r 28s	Director	10e. Street and Number			10f. Zip	Code		l0g. Cîtizen	of What Count	try?
death with the Maryland ms 23a or 28a-f show		30217 Wildlife La	ne		2.	L804		USA	A	
dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deced	ent of Hispanic Origin? ( ify Cuban, Mexican, Pue	Specify Yes or No-	14. F	Race - America	
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ural',	d by	3 Widowed 4 Divorced	Year or Dates:			Water Conference			WII	ite
nat nat	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usua kind of wor	I Occupation k done during most of wo e retired)	orking	16b. Kind of	f Business/Ind	ustry
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filed Hygid ther		17. Father's Name (First, Middle, Last)		120	- 1101	T	me (First, Middle,			
d be antal ced o	To Be	William Joseph Yo	oung				y Lee			
shoul nd Mr mari	Ĕ	19a. Informant's Name/Relationship (1	Гуре, Print)	19b. Mailir	ng Address	(Street and Number or F	lural Route Numbe	r, City or Tov	wn, State, Zip	Code)
alth a 27 ia r trau		James Young/son		302	17 Wi	ldlife Lane,	Salisbu	ry, MI	21804	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avant. If a Medical Evant and must be rediffied at ODGS.		20a. Method of Disposition		Place of Dispo cemetery, crei	osition (Nan	ne of	Date	20c. Locatio	on - City or Tov	wn, State
Page ento nt: if ry or		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	memoval from State	k Ridge			L5/07	Inver	ness, F	L
mit. Dartm Sorta / inju		21. Signature of Funeral Service Lice		2	Pa Malma an	1 Address of Facility 1	Home Pro	fessio	nal As	sociation
permi Depa Impo any ir		Vall R L	rine CECP	,	501 S	vay fuheral now Hill Rd.	, Salisb	ury, M	D 2180	4
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atten for u	lcian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3[	☐Ectopic pr				Date of deliver Month	ry Day Year
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s cert	0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DO	Othor	eath <i>(Check only o</i> Home 5 - Resid		Other (Specify	)
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he Ho in 24 he Fu	edicai	(Check only 2 ☐ Medical Exaπ one)	niner: On the basis of examina and manner stated.	uon and/or in	vestigation,	in my opinion, death occ	urred at the time, o	ate and plac	e, and due to	tne cause(s)
To t To tl	ž	29b. Signature and title of certifier	MIN CAR			License number		29d. Date sig	ned (Month, L	Day, Year)
0		Markon	NO MI		12	006 399	1	5/-	1/0%.	
lo mt		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)			(		
~		Dr. Anu Varadara			ion S	., Suite B	Salisbu	ry, MI	21804	
Stat Registra		31. Date filed (Month, Day, Year) MAY 0 9 2	32. Segistrar's Signa	ture	mark)	,				

DHMH 17 Rev 1/2001

Registra

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** :25 PM May Zitelman 2007 8 Harry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Be The sola Suburban If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F Maryland Oct. 10, 1913 Director 215-05-4930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 X Yes 2 □ No N. Bethesda Director Montgomery Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 U. S. A. 20852 5809 Nicholson Lane, # 1614 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No Army If Yes, Give Year or Dates: WW 2 er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Restaurant Merchant Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Terpentine Morris Zitelman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14330 Cartwright Way, N. Potomac, Maryland 20878 19a. Informant's Name/Relationship (Type. Print) Marc S. Zitelman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Falls Church, Virginia King David Mem. Gdns 5/10/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician respiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pheumonia Diff to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No **Impatient** Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit "Kécords, P.O. Box 68760, been signed by the should be detached this certificate has all director, page 2 a within 24 hours at To the Funeral C completely filled i

Pages 1 and 2 should be filed within 72 hours after death

al Hygiene.

Baltimore, Maryland 21215-0036

10

State

Registrar

30. Name and address of per who completed cause of death (Item 23a) (Type, Print) Daniel

29a. Certifier

(Check only

29b. Signature and title

Medical

Schwartz 31. Date filed (Month, Year)

10

2007

8600 old 32. Redistrar's Signature

and manner stated.

Georgetown Red, Bothesda, Maryland

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

06549

			1 - For Amend #16a Per	State of Marylar FH C867 5257	nd / Department of <b>Jh</b> <i>Certificate of</i>	Health and Ma Death	ental Hygier Reg. 1	1e vo 2 0 0 7	12025
	Dhysisi		Decedent's Name (First, Middle, La	ast)	A .		2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		CLEO	RICKS	ALEXAND		MAY &	21 200	7 11:44 A.M
	Examin	er	4a. Facility Name (If not institution, give	ve street and number) V HEIGHTS AV	ENUE 4b. City, Town,	or Location of Death	OE '	4c. County of Deat	th
	Funeral	ė.	5. Social Security Number 6. S	7. Age (In yrs.	last birthday) If Under 1 Year		8. Date of Birth (Month, Day, Yea		hplace (State or Foreign buntry)
	Director		212-20-3173 Usual Residence of Decedent	1′□M 2ØF	Yrs. World's Days		MARCH 13,1	925 VI	RGINIA
	yland now at		10a. State 10b. County	10c. Ci	ty, Town or Location		~		10d. Inside City Limits
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21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No		Rican, etc.)	Specify:	e, etc.
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Maryland	should be ind Mental marked c	2	SOLOMON	(T D.:.)	KICKS	GRAC	IE E		CKS
Mai	nd 2 sho alth and 27 Is m		19a. Informant's Name/Relationship	ANDER JR. (SON)	19b. Mailing Address (Stree	RTV HEIGHTS	1 (0	y or Town, State, 2 TINDEF L	Zip Code)
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Baltimore,	Pa ant: ury		1 <b>X</b> Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Speci</i>	fy)  G	ARRISON FORE	ST 05-2	9-07 Ou	JINGS M	11145 MD.
Balt	permit. I Departm Importal any Inju		21. Signature of Funeral Service Lice	nsee	ARRISON FORE  22. Name and Addr  NO 2140 A	H H. BR	OKUNUR	FUNERA	AL HOME
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ta			25. Was case referred to medical			26. Place of Death	performed	No 1 ☐ Yes	2□No
Ž	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2█ No	Hospital: 1   Inpatient 2	ER/Outpatient 3 DOA	ther:	ne 5 Residence	6 □Other (Spe	cify)
0 00	Ilng PI		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo		8d. Describe how in	jury occurred	
Division	Attend death actor:	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	e 28e. Place of injury - At he	ome, farm, street, factory, office	Yes 2 No	8f. Location (Street	and Number or Ru	ural Route Number,
Ö	tal or s after al Dire ed in b	Certi	4 Homicide determined	building, etc. (Special	(5)		City or Town, Sta	ate)	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directions.	Medical (	29a. Certifier (Check only one)	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred at the ation and/or investigation, in my	time, date and place, a opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To th within To th comp	Me	296. Signature and title of certifier	A .1 41 .		ise number		Date signed (Monti	
	7		()	= Atkndiwa	121	1118	Ma	y 23, 21	007
	M		30 Name and address of person who	completed cause of death (Iter	3512 New 1	and ld	2121	/	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	why w			
\$4	Registr	ar	MAY 2 5 2007	Brether K	Roseles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** Month savas Toannis Amarantidis 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 642 Oldham Street Baltimore City
Juder 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Director 218-64-0871 70 10-14-1936 Greece Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show be notified at MD Director 1 ☐ Yes 2 ☐ No Baltimore City 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 642 Oldham Street filed within 72 hours after death : Hygiene. xther than "natural", or items 23a Examiner must by Funeral 21224 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter f Health and Mental Hygi Item 27 Is marked other Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental Ioannis Amarantidis 2 Eleni Adamidou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parthena Amarantidis-Wife 642 Oldham Street, Baltimore, MD 21224 Pages 1 a 20b. Place of Disposition (Name of cametery, crematory or other place)
Oak Lawn Cemetery 5-26-07 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility  $Bradley-Ashton \ Funeral \ Home$ 21. Signature of Funeral Service Licensee Statel PA, 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatocellula carcinoma /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe 2 No 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury To the Hospital or Auterian, within 24 hours after death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifier

ollector niel 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

G.M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D44271

29d. Date signed (Month, Day, Year)

5/23/07

			For State Registrar	State of Ma	ıryland			nt of H		nd Men		giene Rag. No.	007	15953
			Decedent's Name (First, Middle, La	st)							Date of Dea			3. Time of Death
E	Physici /Medio		Harold Mark Bowman								MAY 22 2007 12:15 PM			7 12:15 PMM
	Examir		4a. Facility Name (If not institution, give	e street and number)	7.0		4b. Cit		Location of I			4c. (	County of Dear	-
			GENESIS HEALTHLARE THE PINES LASTON JALBOT											
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Yrs.								(, Year)	-   5.71	hplace (State or Foreign buntry)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Exeminer must be notified at Once.		Usual Residence of Decedent								5) 19E	1,1950 Maryland		
												10d. Inside City Limits		
		tor	Maryland Talbot Easton										1. Yes 2 □ No	
		Director	10e. Street and Number 10f. Zip Code									-	en of What Co	untry?
		ral	610 Dutchm	ans Lar	Lane 21061								ISA	
		une	11, Marital Status	12. Was Decedent E Armed Forces?		<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu</li> </ol>				n? (Specify Puerto Rica	Yes or No- in, etc.)	1	14. Race - American Indian, Black, White, etc.	
36		by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	0	1	1 ☐ Yes 2 No Specify:					Specify: White		
Ş		ed	15. Decedent's E	ducation	16a, Decedent's Usual Occupation						16b. Kind of Busine			Industry
212		ple	(Specify only highest grant Elementary/Secondary (0-12)		Completed) College (1-4or 5+)			nd of work done during most of work O NOT use retired)			kirig			
2		Completed	, , , , , ,			Del	live	<u>ry S</u>	ervice	<u>e</u>			rever	ages
D		To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First,								, Middle, Maiden Surname)			
yla			Harold Mi		u Ma					the		-	U++0	40-7-1
Maryland 21215-0036			19a. Informant's Name/Relationship (	7									Town, State,	
			James Bowma	20 / 501		ace of Dispos	sition (N	ame of	Sitt U	Date	net /	20c. Loc	cation - City or	MD 21403 Town, State
ğ			1 Burial 2 Cremation 3		1000									
Baltimore,			4 Monation 5 ☐ Other (Special Structure of Funeral 5, rvice Lice		MICC	22.	Name	and Addres	s of Picility	Annt	200 /	:CI=	nover, Regist	hou .
ä			1 (40)			75	22 C	nnel	land.	in S	0 0 C	Hai	DAVEC A	ND 21076
			23a. Part1. Enter the disease, or com-	plications that caused	the death	. Do not ente	or the m	ode of dyin	g, such as ca				PACE !	Approximate Interval Between
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the ettending physician and polycompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit of polycompletely filled in by the funeral director.		Immediate Cause (Final disease or condition  a. Carcingma of lung with weeked metastas.							trees	. #	Onset and Death		
		resulting in death)  Due to (or as a consequence of):								1034		11/0/01/		
			Sequentially list conditions.	b										
		lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
		Examiner	that initiated events resulting in death) Last	c										
8760,		alE												
Box 687		edlo		d										
		Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy								2	23d. Date of delivery	
œ.		Physician/Medical	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								Month Day Year		
s, P.O.		hys	9 Unknown											101
		by	Part II. Other significant continuous commoning to death but not resulting in the unionlying cause given in Part I.								-	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown		
20		ted	Seizure disordu, relited to met estases Xvos							es 2L				
ခ္ဓ		Completed		· · · · · · · · · · · · · · · · · · ·						_	24a. Was autop	sy	prior to	utopsy findings available completion of cause of
Division of Vital Records,											perfor	2 No	death? 1 ☐ Yes	2 □ No
		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Hospital: 1tnpatient 2ER/Outpatient 3DOA   Other: 4Nursing Home 5Residence 6Other (Specify)										
		. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)  28b. Time of Injury W					4 Nurs		5 Resid	icify)		
		to	Natural 5 Pending 2 Accident investigation						k? Yes 2∐No	2  No				
S		100	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (St.							itreet and Number or Rural Route Number,			
Ö		Certification;	building, etc. (Specify)  City or Town, State)											
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	29a. Certifier Coneck only 2 Medical Exa	nysician: To the best of	f my knov	wledge, death	occurre	d at the tim	ne, date and	place, and	due to the	cause(s)	and manner as	s stated.
	tha H hin 24 tha F nplete	Medi												
}	To To	-	29b. Signature and title of certifier 29d. I									Date signed (Month, Day, Year)		
	1		14M	WWW JOI		00-1 7	3000	1	10/1/				5.22.1	
	1		30. Name and address of person who	L/Y MA	ath (Item	Zga) (Type, F	erint) CHM	ANS	LAN	6	FAR	TON	MA	21601
7	Sta	ite	31. Date filed (Month, Day, Year)	Registra		ture	A 111		EA (1.2)		<u> </u>	1 00	1 11-3	2,001
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DHMH 17 Rev 1/2001

Registrar

MAY 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bay Year 7 4c. County of Death Month **Physician** Ma /Medical 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number)  $\neg m$ 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 😿 F Yrs Director onnecti Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla rathment of Health and Mental Hygiene. ortant: If Items 23s or 28s-f shoy fortant: If Items 27s marked other than "natural", or items 23s or 28s-f shoy injury or other traumatic event, ithe Medical Examiner must be notified at 1 X Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) e17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ٩ 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important; If any injury or 4 Donation 5 Dother (Specify) Memilad 22. Name and Address. Joseph L. 2222 W. N 21. Signature of Funeral Service Licensee uneral 222 W. North Ave. 23a. Part | Enter the discusse, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart full re. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) CONGESTIVE **Physician** /Medical Due to (or as a consequence of) Examiner METORCUETAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 97397 To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Persidence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: in 24 hour. the Funeral Directory filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30408 address of person who completed cause of death (Item 23a) (Type, Print) アノトノ 30. Name and CIBETIT 13mD 2600 MESVINS 31. Date filed (Month, Day, Year) Begistrar's Signature State 5 2007 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month AMES RNEST 24 Ma 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes
5. Social Security Number Balti more 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
NEW YORK **Funeral** Months Days 1**⊠**M 2□F Hours Min. Director Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Cjlizen of What Country? LUCY ROAD

12. Was Decedent Ever in U.S.
Armed Forces? 14. Race - American Indian, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ZYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify. <u>≽</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SPIRATORY TITERAPIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIHORE IANICE Baltimore, 20c. Location - Qity or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DWINGS MILLS 21. Signature of Funeral Service Licensee 22. Name and Address TR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALVIE MYOCARDIAL 20 MINUTES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Physician/Medical as t IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed 2 No Vita 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTINGRE MI) HUSPITAL CURTIS 32. Registral 31. Date filed (Month, Day, Year) 2

DHMH 17 Rev 1/2001

State Registrar

#### 07-03896

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Ct-t- of Mandand /	Department of Health and Mental	Hygielic
State of Maryland /	Department of Floater and	30

e Velma Bradsha	w State of Maryland / Department of Health and Mental Hygier For State Certificate of Death	Reg. No.
De	gistrar 2 Dat	e of Death 3. Time of Death
Examiner	Tackie, Velma Bradshaw May	y 22, 2007 Year 1440 hrs
4	A. Facility Name (if not institution, give sitect and harmony)  Middle River	Baltimore County
Funeral 5	7 Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. D	ate of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
dileter	16-84-6564 1 M 2XF 41 Yrs. Months Days Hours Min.	7-15-65 Country) MD
ī	sual Residence of Decedent	10d. Inside City Limits
8 4	MD 10b. County Middle River	1 Yes 2 10
Maryland 28a-f show any dat once. rector	On Street and Number 10f. Zip Code	10g. Citizen of What Country?
MD 21215-0U30 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene h sand Mental Hygiene umatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	9827 Charbonic Lane 21220	Yes or No- 14. Race - American Indian, Black,
ms 23.	1. Marital Status 1. Married 2 Married 2 Married 1. Was Decedent Ever in U.S. Armed Forces? 1. Ves 2 No	white, etc.)
or death	2 Middued 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: Black
tural".	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)	one 16b. Kind of Business/Industry
72 hor "na sal Exa	College (1.4 or 5t)	MOTORN
Z1Z13-UU30 uld be filed within 72 hour Mental Hygiene, marked other than "natu c event, the Medical Exan TO Be Completed	17. Father's Name (First, Middle, Last)	t, Middle, Maiden Surname)
To Be Completed by  To Be Completed by  To Be Completed by	labolte loe Elliot Larina	Route Number, City or Town, State, Zip Code)
d Men d Men is marl	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of Rula)	
MC 2 sho alth and m 27 is raumat	20b. Place of Disposition (Name of cemetery,	te 20c. Location - City or Town, State
Ore,	1 XBurial 2 Cremation 3 Removal from State	9/07 Balto.MD
	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22 Name and Address of Facility	Freneral Services
Balt permit. Depart Impor injury	Li Clata MOSIAS VIII TOUR TOUR	pirator arrest, shock, or heart Approximate Interv
ysician	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or res failure. List only one cause on each line.	Between Onset ar Death
Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
	Compatibility conditions b.	
iner	if any, leading to immediate cause. Enter Underlying Cause	
ed Misit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
b, & we executed sician and ourial - transit	d. NEWFORDED OF MED OF 111/07 THE	
e la si p	X UNPENDED  A##################################	23d. Date of delivery
cords, P.O. Box 6876l law requires that the death certificate has been signed by the attending play that be detached for use as the to mpleted by Physician/IM.	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy	, Month Day Year
ox 6	1 Yes 2 No 9 V Unknown 9 Unknown	double and double
D. Bo t the der by the ached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
P.O. res that the signed by I be detach		24a Was an 24b. Were autopsy findings avail
Records, The law required ficate has been significate has been significant has been significa		autopsy performed? death?
Recc The lav icate ha	26.Place of Death (Check onl	1 tes 2 110 1 tes 2
tal Rection: The certificate ector, page	25 Was case referred to medical	Home 5 Residence 6 ✔ Other: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  The law rector: After this certificate has been selled in by the funeral director, page 2 should be refrication: To Be Completes	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28	Bd. Describe how injury occurred
nding th. r: Aft	1 Natural 5 Pending Fnd 5/22/2007 Fnd 2:38 pm	unk  8f. Location (Street and Number or Rural Route Number,
ivision or Attendath Director: Lin by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29e. Place of Injury - At home, farm, street, factory, office building, etc. 29e.	86. Location (Street and Number of Rula Roble Rule) 9827 Charbank Ln. Middle River,
Division of spital or Attending I sours after death. neral Director: Afte filled in by the function:	determined (Specify) found in residence  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and discharge 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and discharge 1 Certifying Physician:	us to the cause/s) and manner as stated.
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detained for the funeral director. To Be Completed by		
To the within To the company of the the company of the the the company of the the the the the the the the the the	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, rear)
	Many Massel de O.C.M.E.	May 23, 2007
	30. Name and address of person who completed cause of death (Item 23a)	1201
Ø	Wellska Blassell, WD / Wellstan I	
Stat	e 31. Date filed (MAN Pag. Year) 2007 33 Registrar's Signature	

DHMH 17 Rev 1/2001

ORIGINAL

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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

5

		-	- For Amend Item 3 State of per di	f Maryland / Der 5.,g867,05/25	partment of Health ar 207 dhb ertificate of Death	nd Mental Hygie	ne ;
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year Unknown M
	/Medic	al	Josie Priscilla C	mber)	4b. City, Town, or Location of	Mary	4c. County of Death
	Examin	er		en St	Baltimore		City
Ī	Funeral Director		5. Social Security Number 6. Sex 1 M 2017	7. Age (In yrs. last birthday Yrs.	Months Days Hours	Min. 8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)
	and		Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or I	_ocation		10d. Inside City Limits
	Maryl	tor	MD	Baltim	ore		1 Nes 2 No
	th the	Director	10e. Street and Number	6.1	10f. Zip Code	10g	. Citizen of What Country?
	s 23a	rai	114 [ N. Calhoun	edent Ever in U.S. 13	. Was Decedent of Hispanic Origin	n2 /Specify Vec or No	14. Race - American Indian,
	ter de ritem	Funeral	11. Marital Status 12. Was Dec Armed For 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	orces?	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Black, White, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent, the Madical Examinar must be notilled at	by	3 Widowed 4 □ Divorced If Yes, G Year or D	ve	1 ☐ Yes 2 No Specify:		Specify: Black
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation re kind of work done during most of DO NOT use retired)	of working 16	b. Kind of Business/Industry
121	filed withlr Hyglene. other than	dmo	Elementary/Secondary (0-12) College (	1-4or 5+)	lasekeeping	j	tealth Care Industry
b D	be filed ital Hyg id other event,	Be C	17. Father's Name (First, Middle, Last)	,		s Name (First, Middle, Ma	iden Surname)
<u>ya</u>	2 should be and Mental is marked of aumatic even	T <sub>O</sub>	Henderson Johns		11/11	lie Davi	5
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healin and Mental Hygiens is the fire 23 or 28a-1 show then 71 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at		19a. Informant's Name/Relationship (Type, Print)	i 2	ling Address (Street and Number	5 D 1	timere MD 21217
	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	20b. Place of Disp			c. Location - City or Town, State
altimore,	Pages nent of I ant: If its arry or o		1 ■ Burial 2 □ Cremation 3 □ Removal from  '4 □ Donation 5 □ Other (Specify)	State	Pork Com D	5-18-201	Baltimere MD
Balt	permit. Pages 1 a Department of Hea Important: if Item any injury or othe		21. Signature of Juneral Service Licensee	let A.	22. Name and Address of Facility tacketts Funer	alChapel	814Upshur S+ NW. Washington DC. Approximate
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not e each line.	nter the mode of dying, such as ca	ardiac or respiratory arrest	t, Approximate Interval Between Onset and Death
層	Frrysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ypertens	ion		
	Examiner		Due to	that a consequence of):			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of):	2010:1		
	ecuted and -transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):	estero		
8760,	icate be executed physician and s the burial-transit	aiE	Due to	un as a consequence on).			
687	ificate g phys as the	edicai	d				17
Вох	leath certific attending p	Physician/M		itcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery  Month Day Year
O. E	the at thed fo	ysici	1 Pes 2 DNo 9 Unknown		Other (specify)		Month Bay
<b>Q</b>	The law requires that the death certificate has been signed by the attending of agge 2 should be detached for use as	by Ph	Part II. Dther significent conditions contributing to	leath but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rds	w requires been sig should be					1 Tes	2 No 3 Probably 4 Unknown
Records,	law re nas be e 2 sho	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
al H							No 1 Yes 2 No
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐	Inpatient 2 ☐ ER/Outpati	Other	of Death (Check only one) sing Home 5 siden	ce 6 ☐Other (Specify)
of	두 등 등	H	27. Many r of Death 28a. Date	of Injury 28b. Time	of 28c. Injury at	28d. Describe how	11 27
sior	Attending Ph r death. ector: After th by the funeral	catio	2 Accident investigation		M 1 Yes 2 N		A STATE OF THE STA
Division	or At after of Direct in by	Certification;	determined 200. Flac	e of Injury - At home, farm, : ling, etc. (S <i>pecify)</i>	street, factory, office	City or Town,	et and Number or Rural Route Number, State)
_	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Medical C	(Check only 2 Medical Examiner: On the		ath occurred at the time, date and investigation, in my opinion, death		se(s) and manner as stated. e and place, and due to the cause(s)
	within Fo the	Me	29b. Signature and title of certifier	< 00 >	29c. License number	290	1. Date signed (Month, Day, Year)
			resal *	< YYI.D.	D0060	702	5/17/07
	4		30. Name and address of person who completed cau	se di death (Item 23a) (Typ	e, Print)	000 150	1 Division Ct
	Sta	to.	31. Date filed (Month, Day, Year) 32.	Registrar's Signartire	ional Traiting	OCT YW	Ratt MD 21217
	ા Registi		31. Date filed (Month, Day, Year) 32.	il pools	•		Decer in Desiri

			For State Registrar	State of Ma		epartment of F Certificate of			giene Reg. No.		
	8		Decedent's Name (First, Middle, Last,	)		/3		2. Date of De Month		Year	3. Time of Death
	Physici: /Medic		Annie			Coleman	1	May	18	2007	11:32 PM
	Examin		4a. Facility Name (If not institution, give		1		r Location of Death	/	4c. C	County of Death	
	<u></u>		The Johns HOPK, 5. Social Security Number 6. Se.	10	(In yrs. last birt	Baltimo		8. Date of Bir	th	NA 9 Birthe	Nace (State or Foreign
	Funeral Director			M 2 KF	0.0	rrs. Months Days	Hours Min.	(Month, Da	ıy, Year)	8 Cour	place (State or Foreign htry) Ala.
			Usual Residence of Decedent		10 01 7			1 20 0			
	arylar ehow	7	10a. State 10b. County		10c. City, Town	altimore				1	0d. Inside City Limits  1X Yes 2 □ No
	the M	Director	Md. NA			10f. Zip Code			10a Citiza	en of What Cour	
	N with		1401 N. Lakew	ood Ave.	Apt.	15 2121	3			USA	,
30	hours after death with the Maryland turel; or Items 23s or 28s-f show al Extended rount by notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 Yes X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Black	ean Indian, etc. a C K
5	72 hours "natural",		15. Decedent's Edu (Specify only highest grad	cation	16a.	Decedent's Usual Occup (Give kind of work done	pation	kina	16b. Kin	d of Business/In	dustry
9500-61212	F . C .	Completed	Elementary/Secondary (0-12) 10th grade	College (1-4or 5-	-)	life. DO NOT use retired	d)	Wilg	Joh	hns Hopkins Hosp	
-		Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	, Maiden S		
Jar	should be and Mental marked o	To B	Willie		Har	ris	Areth	a		Tat	e
, Maryiand	12 a - 7		19a. Informant's Name/Relationship (T) Angela Leach	rpe, Print) Grandda		Mailing Address (Street 2840 L	and Number or Run ake Ave	., Bal	er, City or timo	re, Md	. 21213
altimore,	S to T o		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other place		Date		ation - City or To	
Ě	Pages Iment of tant: if it fury or o		4 Donation 5 ☐ Other (Specify)		Gard	len of Fai		5-07	Ba	ltimor	e, Md.
Ra	permit. Page Depertment Importent: if eny injury or		21. Signature of Funeral Service Licens	" wan	س	22. Name and Addre		March ve., B	F.H alti	. East more,	Md. 21202
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused ne cause on each lin	the death. Do r e.	ot enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Line	Physician		Immediate Cause (Final disease or condition resulting in death)	. Severe	Seps,	5					18 hours
	/Medical Examiner		Toolaing in dollar)	Due to (or as a	consequence	- 11					3 days
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	gilure			Jagy		
	cuted nd ransit	Examin	that initiated events	. Preumo	nia					7 days	
Ď,	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last	Due to (or as a	consequence	of):					/
8/60	cate be executed physicien and the burial-transit	dical	•	d							
O. Box 6	The law requires thet the death certificate hes been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	Fetal death	3 ☐ Ectopic pregnanc; 5 ☐ Other (specify) _	у		23	3d. Date of delive Month	ery Day Year
1	ires thet the de signed by the a l be detached f	by Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	the underlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to t	he cause of death?
rds	w require been sig should b							10	Yes 2	No 3□ Prot	oably 4 Unknown
Vital Records,	The taw re te hes ber age 2 sho	Completed								24b. Were auto prior to co death? 1 \( \text{Yes} \)	opsy findings available impletion of cause of
II		BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o		10 163	20140
	Physic this ce al direc	To	TO THE ZERONO	lospital:			4   Nursing H	ome 5□ Resi	dence 6	Other (Specif	(y)
o o	ding P. h. After t funera	tion;	27. Manner of Death  1. Natural 5 Pending investigation	28a. Date of Injury (Month, Day	/ Year) 28b. 1	ime of 28c. Injury Wor	ryat rk?  Yes 2 □ No	28d. Describe	how injury	occurred	
Division of	or Atten fler deat director: in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, fa (Specify)	rm, street, factory, office		28f. Location ( City or To		Number or Rura	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerei Director: After this certific completely filled in by the funeral director,	Medicai Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination an	, death occurred at the tid d/or investigation, in my o	me, date and place	, and due to the	cause(s) a	and manner as s place, and due to	stated. o the cause(s)
	Fo the within : To the	Mec	29b. Signature and title of certifier	4.14 mailler 3(d)	. vul	29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	3		Andrew Kou Me	dical Doc	stor	Res	-000	1	May	19,200	7
	9		30. Name and address of person who o					. 1 -	C.	2 11	Maryland
	C.		Andrew Kau, The 31. Date filed (Mgnth, Day, Year)	Johns Ho 32 Registra 07	PK,n5 H	ospital, 600	North	Wolfe.	Street	r, Daltin	nore, 21287
	Sta Registr		MAY 2 5 20	07 Co 2148	15.	Signal .					
			WAT ~ J			*					

		1	For State Registrar	Otate of Marylan		rtificate of			Rec	. No. 2	117	1597
4 # /N	ysicia Medica amine	n al	1. Decedent's Name (First, Middle, Las  Edward W. Ca  4a. Facility Name (If not institution, give	asson e street and number)		4b. City, Town, o		May May	ate of Death onth y 23	4c. County		3. Time of Death 4:15p M
Fun Dire			5. Social Security Number 6. S	oad ex 7. Age ( <i>In yrs.</i> ▼M 2□ F 93	last birthday) Yrs.	If Under 1 Year Months Days	ddle R	Hrs I & Do	te of Birth conth, Day, 1	(ear) 1914		lace (State or Foreign try) 7 Land
Maryland	ified at		Usual Residence of Decedent  10a. State 10b. County  MD Baltin		y, Town or Lo	ocation MIddle	River				11	0d. Inside City Limits 1 ☐ Yes 2X No
th with the	st be not	Funeral Director	10e. Street and Number 314 Earls Road	3		10f. Zip Code 212	20			g. Citizen of V JSA	What Coun	try?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examiner mu	þ	11. Marital Status 1	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ XNo	lispanic Origin an, Mexican, P Specify:	? (Specify Ye Puerto Rican,	es or No- etc.)	Bla	ce - Americ ck, White, o	etc.
Baltimore, Maryland 21215-0036  Dermit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or	the Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 8th	ducation ade completed)  College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired tenance	oation during most of d)	working		6b.Kind of B Baltir		spice
/land : uld be filed Mental Hyg	itic event,	To Be C	17. Father's Name (First, Middle, Last, Robert N. Cas				18. Mother's Mar			aiden Surnar Hoehi		
and 2 sho	er trauma		19a. Informant's Name/Relationship ( Joanne B. Cas	sson / wife	31	ng Address (Street 4 Earls		Balt	imore	MD 2	21220	)
imore Pages 1 ment of He	lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil	Removal from State Ba	yview yview	osition (Name of matory or other place Cremate		5/25/		Oc. Location Baltin	-	
Ball permit. Depart	any in		21. Signature of Funeral Service Licer	2 Kin	7	2. Name and Addre	y Fune	eral	Home	of E		
Physic /Med	_		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deal one cause on each line.  a.  Due to (or as a consec	y DI	ter the mode of dyin	ng, such as ca	rdiac or resp	iratory arres	st,		Approximate Interval Between Onset and Death
Exam	iner	edical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consected)  Due to (or as a consected)	hao juence of):	noeal	Cand	ldi	es is	S 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		1 week
	should be detached for use as	Physician/Me								23d. Date of delivery Month Day Year		
Vital Records, P.O. Box sician: The law requires that the death cercertificate has been signed by the attending.	uld be detac	by	Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cause giv	ven in Part I.	2	3e. Did toba			ne cause of death? eably 4 □Unknown
I Reco	page 2 sho	Completed						_	4a. Was an autopsy perform ☐ Yes 2	ed?	prior to con death?	psy findings available mpletion of cause of 2  No
vision or Vital Attending Physician: r death. ector: After this certifice	ector	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatie	Wo	ner: 4□ Nursi ry at	28d. D	Resider	) nce 6 □Otl v injury occu		y)
Division or Hospital or Attending Phys 4 hours after death. Funeral Director: After this	ed in by the	Certification:	2	e 290 Place of injury - At h	ome, farm, st		1163 2 110	28f. Lo	ocation (Stre lity or Town,	eet and Num State)	ber or Rura	al Route Number,
DIV To the Hospital or within 24 hours afte To the Funeral Dir	pletely fille	Medical (	(Check only 2 Medical Exa	nysician: To the best of my kniminer: On the basis of examinand manner stated.		nvestigation, in my	opinion, death					
To the within 2	TI00	Z (	29b. Signature and title of certifier	Dry Atten	`	np 29c. Licens	1011	8	1/	d. Date signed	ed (Month, 4, 20	
3			30. Name and address of person who 35 (2 New and	Rd 21218	PA	-(-	1//1 NAR	TZ1	D.			
RODHMH 17 F	Sta egistr	ar	31. Date filed (Month, Day, Year) MAY 2 5 2007	32. Registrar's Sign	Apart					<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** 0:29 A.M Ictoria 200 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA agnes Health Care timore 8. Date of Birth (Month, Day, 5. Social Securit 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Number **Funeral** 5T7.54.1865 1 □ M 2 💢 F Months Min. Director 10 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Catonsville Baltimone 1 ☐ Yes 2 XNo MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 80 Winters ano Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 17. Father Mame (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Osbourne Dorothi ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) Randallstown MD 21133 Tereva Fulcher Daughter ane' 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State St. Alphonsus Cemetery Woodstock, MD 05/20/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Funeral Service Licensee augha C. Greene Funeral Sovics 8728 Koad Kandallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** in Known disease or condition resulting in death) Vascular Discore /Medical Examiner Sequentially list conditions, if any leading to inner date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) by the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) I□Yes 2□No 9∏Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral. 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nay 24, 2007 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) Reis le Agnes //2 32. Registrar's Signature 900 Caton Avene Baltimere Many land 31. Date filed (Month, Day, Year State 2 5 Registrar

			1 - For State Registrar	State of Ma	rylan		artmen rtificat			ind M		giene Reg. No.	007	16979	
	Physici /Medic		Decedent's Name (First, Middle, Last,     Margie Dunn	)							2. Date of Dea Month May 24	Day	Year 007	3. Time of Death 1:40 <sub>a M</sub>	
	Examir		4a. Facility Name (If not institution, give Mariner Healthca	re Center			E	Balti					County of Death	n	
182	Funeral Director		5. Social Security Number 246–66–0476 6. Second 1 December 1 Decem	7. Age	63 (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt 10/25/	. 9 <del>4</del> 3	9. Birth	nplace (State or Foreign untry) NC	
	Maryland -f ehow	tor	10a. State 10b. County	lifax	10c. City	, Town or Lo	Roan	oke	Rapi	.ds				10d. Inside City Limits  Yes 2 □ No	
	3s or 28s	i Direc	10e. Street and Number 1026 B Hamilton S	treet			10f. Zip	<sup>Code</sup> 278	70			10g. Citi	zen of What Co	untry?	
980	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f ehow spiritury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💯 Divorced	12. Was Decedent 8 Armed Forces? 1  Yes 2		'	Was Deced If Yes, spec 1 ☐ Yes	crfy Cubar	spanic Orion, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: B		
21215-0036	d within 72 ho giene. er than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary(Secondary (0-12)	cation e completed) College (1-4or 5	+)	16a. Deced (Give life. L	kind of wo DO NOT u	rk done d	uring most	of workir	ng	16b. Ki	6b. Kind of Business/Industry  Church		
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	and 2 sho ealth and I m 27 is mu		19a. Informant's Name/Relationship (T Denise Ezenneka /	Daughter		521	3 Haz	elwo	nd Numbe Od Av	renue	, Balt:	Lmor	r Town, State, Z e, MD 2:	1206 	
Baltimore,	Pages 1 ment of H ant: if Iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	C	lace of Dispo emetery, cren noke Si	natory or o	ther place	tery		30,200°		cation - City or T Garysbu		
Ball	Dermit Depart Import eny in		21. Signature of Funeral Service Licens	Buall.	uall		harle 501 E	ad Addres S L. ast	Stev Stev Fort	ens Aven	Funera: ue, Ba	L Ho	me Inc ore, MD	21230	
16	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused ne cause on each lin a. Mut	the death	n. Do not ent	reb	le of dying	such as	cardiac o	/	1	ident	Approximate Interval Between Onset and Death	
	/Medical Examiner	L	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as	1	vence of):	He	art	- fz	uli	ne				
0,	cate be executed physicien and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (of as a Due to (or as a	n M a consequ	y	ar	ter	y	d	isea	se	2		
68760,	tificate be ng physici as the bu	Medicai	•	d		0						-			
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  \$€ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 🗌 Fetal	death 3	Ectopic pr Other (sp					a di	23d. Date of deli Month	very Day Year	
rds, P.	w requires that been signed b should be deta	ב	Part II. Other significant conditions co.	ntributing to death by	not resu	ulting in the u	nderlying c	ause give	n in Part I.			obacco u 'es 2[		the cause of death?	
Division of Vital Record	n: The law requicate has been r, page 2 should	Completed									24a. Was autop perfo 1 🗆 Yes	sy	24b. Were au prior to death?	topsy findings available completion of cause of	
Ĭ	sicial certif recto	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
on of	Attending Physician: r death. ector: Atter this certific by the funeral director, i	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie	у	28b. Time of Injury		28c. Injury Work	44CU NU	2	ne 5 🗌 Resid 28d. Describe f		6 □Other (Spec y occurred	cify)	
Divisi	in Little	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At ho	ome, farm, str	eet, factory	, office		2	28f. Location (S City or Tow	Street an In, State	d Number or Ru )	ral Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Direct completely tilled in 1	edical	29a. Certifier (Check only one)  Check only 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examinat	wledge, death tion and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the e	date and	and manner as place, and due	stated. to the cause(s)	
)	To T com	Z	29b. Signature and title of certifier	MD	(		290	D 2	number 25	39	1	29d. Dat	e signed (Month	1-2007 1-2007 mpz1239	
4	1		30. Name and address of person who co	S60/- L	eath (Item	23a) (Type,	Print)	L 1	Blu	d	18.	N	more	mp 21239	
	Sta Registr		31. Date filed (Month; Day, Year)	32. Rigistra	ır's Signa	ture	nach!	g							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Antonio James Ditzel 1525 PM 22 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Year) 12/3/1959 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days M 2□F 47 220-76-9536 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21211 USA 3860 Falls Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unknown College (1-4or 5+) Scrap Metal Free Lance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peggy Marie Monroe Joseph Thaddeus Ditzel Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3860 Falls Rd.Baltimore, MD 21211 Linda Ditzel/stepmother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/07 Beltsville. MD Chesapeake Crem. 22. Name and Address of Facility 8717 Giren Pastures Dr. Towson, mo 21. Signature of Funeral Service Licensee 21286 Cremation + Funcial Algeratures

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien important: if item 27 is marked other the any injury or other traumatic event, the once.

**Physician** 

/Medical

Examiner

MD

**Funeral** 

Director

"naturai", or items 23a or 28a-f show idicai Examiner must be notified at

Director

Funeral

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Completed

Be

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ding physician ase as the burial ed by the a detached t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760, $^{\sim}$ 

or Attending

shock, or heart failure. List of	only one cause on each line.	tor the mode of dying, such as cardia	o or respiratory arrest,	Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alcoholisa  Due to (or as a consequence of):	1		
Sequentially list conditions, if the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Alcoholic  Due to (or as a consequence of):  d.	C Virus Hepatitis		75 years 75 years 75 years
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the u	underlying cause given in Part I.		ise contribute to the cause of death?
			24a. Was an autopsy performed? 1  Yes 2  1 10	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			ath (Check only one)	
1 □ Yes 2 □ No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing I	dome 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death  1	ation	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		reet, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
	g Physiclan: To the best of my knowledge, dea Examiner: On the basis of examination and/or in and manner stated.			
OOL Circular and title of contificat		29c License number	20d Det	a signed (Month Day Voor)

Registrar

State

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signal

Manchas

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8,20 AM /Medical Facility Name (If not instituti 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 timore Birthplace (State or Foreign Country) **Funeral** Months Min. 1**⊠**M 2□F 5 2 **Director** land Usual Besidence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No tin ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Race - American Indian, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ  $\Omega\Omega$ 19a. Informant's Name/Relationship (Types 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Moria Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician /Medical Due to (or as a consequence of): Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Box 68760,0 to (or as a consequence of): Due physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably V☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an certificate has autopsy Division or Vital Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes VI No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 ☐ Pending investigation Injury ithin 24 hours after death.

o the Funeral Director: Aff
ompletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

			For State Registrar	State	of Marylan	-	artment of F		and M		giene Reg. No.	007	16982
- 55			1. Decedent's Name (First, Middle	e, Last)					]	2. Date of De Month		Voor	3. Time of Death
1	Physici /Medic		Mary Louise	Dunn					_	May	19 <sup>Day</sup>	2007	5:30P <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution				4b. City, Town, o				4c. Co	unty of Death	
مضيد			Ellicott City 5. Social Security Number	Nursing			Ellico			0.5		Howar	
m.	Funeral Director		196-12-2542	1 M 2 <b>X</b> F	7. Age (In yrs.	1451 Dirinday) Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)	Cour	* / _
file.			Usual Residence of Decedent			: /				Feb. 7	,1920	Penn	sylvania
	ryland how at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
	e Ma 3a-f s tiffied	Director	Maryland Howar	rd.		Colu	mbia						1 □Yes 2 No
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	ter de	E I	<ul><li>11. Marital Status</li><li>1 Never Married 2 Marr</li></ul>	Armed F		.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican	, Puerto	Rican, etc.)	14.	Black, White,	
21215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2 ☐ MyNo	Specify:			Sp	pecify: Wh:	ite
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121	e filed withir al Hygiene. I <b>other than</b> vent, the M		17. Father's Name (First, Middle,			Teach	er.	18 Mothe	r's Name	(First, Middle,			
Maryland	P ₩ P P	To Be	James W. Dunn	,						Brown	Waldell Ou	mamey	
ary	ᄯᇰᆯᇀ	F	19a. Informant's Name/Relations			19b. Mailii	ng Address (Street				er, City or To	own, State, Zip	Code)
	nd 2 lith a 27 is r tra		Janes Dunn	(Sister)		1055	6 West Gr	anada	Dri	ve Su	n City	, AZ 85	5373
J. C.	iten		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation	2. Demous from	20b. F		sition (Name of matory or other plac			ate		ion - City or To	
<u>=</u>	mit. Pages bartment of l cortant: If its injury or or		4 □ Donation 5 □ Other (S		Ca	lvary	Cemetery	5	-25-	2007	Pitts	burgh,	PA
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee Hzulm	nami	5	Name and Addre Witzke Fu 555 Twin	ss of Facility Ineral Knoll	Hon S Ro	es, Ind	Iumbia	., MD 21	1045
- gex			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat each line.								Approximate Interval Between
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5.		<u></u>	Sequentially list conditions,	b. H	Or as a conseq	E NS uence of):	ION					^	10 neus
dr.	uted J ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
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_	To the Hospital or Attending Physician: within 24 hours after death after this certific completely filled in by the funeral director, completely filled in by the funeral director,		29a. Certifier 1 Certifyin	g Physician: To the	e best of my kno	wledge, deat	n occurred at the tir	ne, date an	d place,	and due to the	cause(s) an	d manner as st	ated.
	he Hc in 24 l he Fu pletely	Medical	(Check only 2 Medical	Examiner: On the t	pasis of examina	ation and/or in	vestigation, in my o	pinion, deat	th occurr	ed at the time,	date and pla	ace, and due to	the cause(s)
	To the vithing the confidence of the confidence	M	29b. Signature and title of certifie				29c. License	e number			29d. Date s	igned (Month,	Day, Year)
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	18		30. Name and address of person	who completed cau	se of death (Iten	23a) (Type,	Print)	0-	Pan	d	ude 1	10 1	YP
	Sta	10	29b. Signature and title of certifie  Symp  30. Name and address of person  Shawnma  31. Date filed (Month, Day, Year)	te Ju	Registrar's Signa	463C	SUMMA	90 1		,	0100	noic	21042
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			1 = For State Registrar	State of Maryla	ne, 0 U	7	16083					
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	/Medio		4a. Fecility Name (If not institution, give s	treet and number)	Om		Location of Death	May	4c. County of	Death	12:1J PM	
	Funeral	H	5. Social Security Number 6. Sex	7. Age (In yr	enter s. last birthday)	If Under 1 Year	altimo If Under 24 Hrs.	8. Date of Birth		Rirthola	ace (State or Foreign	
	Director			M 2₽F 86	Yrs.	Months Days	Hours Min.	(Month, Day, You	ear)	Counti lary	y)	
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	ath with 23a or	rai Di	406 N. Beechwood	Avenue		21228	3		USA		,,.	
036	urs after des al', or iteme xammerm	Completed by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2√2 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	America White, e Whit	tc.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or theme 23a or 28a-f show or other traumatic event, the Medical Examinar must be multiped at		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give		ation furing most of work! )	ng 161	b. Kind of Busin		,	
	be filed tal Hygid d other	Be Co	17. Father's Name (First, Middle, Last)		П	omemaker	18. Mother's Name	(First, Middle, Mai		Home	2	
Maryland	should be nd Mental marked c	은	Samuel Lewis Casc  19a. Informant's Name/Relationship (Type		10h Mailie	- Address (Cares	Alice	Crosby	T	- 1 - Ter - 1		
	and 2 sho ealth and m 27 is m		Alice Marie Falter	•	Lanca de la constante de la co		Court;				,	
nore	Pages 1 nent of He int: if Iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		natory or other place	9)		Location - Cit			
altimore,	permit. Pages Department of Important: If I any injury or once.		4 Donation 5 ther (Specify)  21. Signature Fundal Service Lice se	е	22.	k Cemeter	s of Facility ter ome of Ca		timore; on_Schw		-	
e E	80 2 2 3		23a Part 1 Enter the glease or complic	MO12	- 10	630 Edmor	ıdson Avei	nue: Cato	${ t nsville}$	, MI	21228	
	Physician /Medical		23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. Interval Between Onset and Death disease or condition resulting in death)  a. Level roll Voscul av Accident Manner of the mode of the mode of the cardiac or respiratory arrest, and proximate Interval Between Onset and Death Onset a									
	Examiner		Sequentially list conditions, b	Covoni	ory	Arter	y Dis	ease		4	/ener	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quency of):	/				/		
8760,	cate be executed ohysicien and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of);							
9	cate phy:	Medicai	IF FEMALE:							-		
O. Box	The law requires that the death certificate has been signed by the ettending to age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 W No 9 □ Unknown	ic. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date o Month		r Day Year	
ords, P.	w requires that the de been signed by the s should be detached f	by	Part L Other significant conditions conditions conditions	ributing to death but not re	sulting in the un	derlying cause give	n in Part I.	23e. Did tobac		te to the	cause of death?	
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	yelcian: is certific director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	spital:	☐ ER/Outpatient	3□ DOA Othe	26. Place of Death	Check only one	e 6 □Other /	Specify)		
on ot	F E E	ion: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how i		Specily)		
DIVISION	il or Attendi after death. Director: A d in by the fu	Certification:	2 Accident investigation 3 Surcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At l building, etc. (Spec	home, larm, stre		'es 2 □ No	8l. Location (Stree City or Town, S	t and Number o tate)	or Rural I	Route Number,	
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 10 Certifying Physic (Check only one)	i cien: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the caused at the time, date	e(s) and manne and place, and	er as stat due to t	ed. he cause(s)	
)	To the transfer of the transfe	Σ	29b. Signature and title of certifier	2mm 1 1	no	29c. License		29d.	Date signed (A	fonth, Da	ay, Year)	
	16		30. Name and address of person who cor	8.4	m 23a) (Type, F	Print)	altinion	e Ma	ry lan	d	21227	
	Sta Registr	41	31. Date field (Month, Day, Year)	32. Registrar's Sign	nature		** \$   1 / 1 / 1	- / 1	-/-			
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ORIGINAL

Amend #7&8 Per Fit G867 3/29/07 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 600 Year Month **Physician** Willert Elmore 05 2007 22 CLM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NA Genesis N.H. Hamilton Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)
Feb. 28, 1930 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex **Funeral** Months Days 1⊠M 2□ F 217-24-2148 Yrs. 77 Director Md. Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10h County 10e State or milt. Pages I and 2 should be filed within 72 hours after deeth with the Maryler Copartment of Health and Mantal Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Mantal Examiner must be notified. Yes 2□No Directo Md. NA Baltimre 10g, Citizen of What Country? 10e. Street end Number 10f. Zip Code 1401 N. Lakewood Apt. 321 21213 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: δ If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Various 10th grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be George Elmore Augusta Lawson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Naomi Wagstaff 21213 Sister 1512 N. Linwood Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-24-07 Baltimore, Md. Greenmount Cem. 22. Name and Address of Facility 21. Signature of Fundal Service Licensee March F.H. East molan, 1101 E. North Ave., Baltimore, Md. 2120 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examiner ed by the attending physicien end detached for use as the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Inknown signed Completed by should be c 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy eftar death.

Director: Affer this certificate has to in by the funerel director, pega 2: 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: oursing Home 5 Residence 6 Other (Specify) 1 Yes 22No Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 5 Pending investigation Injury 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours e To the Funerel C 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie KWISTAM SIFE 10001,20 2-55-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSIS Sunfand Mangland 21204 North Charles 31. Dete filed (Month, Day MAY 2 2. Registrer's Signature Yeer) State

**DHMH 16 Rev 6/95** 

Hegistrar

			1 - For State Registrar	State of Marylar	•	ent of Healt cate of Dea		al Hygiene Reg. No	211117	16985
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Las	ert			M		2007	3. Time of Death  2:55 A M
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	Director  wow	tor	Usual Residence of Decedent  10a. State  10b. County		ty, Town or Location	ARIA	12-	-27-4		10d. Inside City Limits 1
	death with the Maryland me 23a or 28e-f ehow rmust be codiffed at	ral Director	10e. Street and Number  60 GREENBLAD	E GARTH	10	Zip Code	45	10g. Cit	izen of What Cour	ntry?
9600	d within 72 hours after death with the Marylar jene. rithen "netural", or iteme 23a or 28e-f ehow the Madical Examinar must be collified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		ecedent of Hispanic specify Cuban, Mex es 2 No Spec	o Origin? (Specify Yekican, Puerto Rican, ecify:	es or No- etc.)	14. Race - Americ Black, White, Specify:	
121215-0036	i filed within 72 h I Hygiene. other then "netrient, II's Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give kind o	Usual Occupation of work done during to Use retired)			ind of Business/In	odustry TRY
Maryland	2 E &	To Be	17. Father's Name (First, Middle, Last)  ALVIN  19a. Informant's Name/Relationship (7)	Richardso	1		lother's Name (First,	JES	,	- 0-44
	1 and 2 s Health ar em 27 is other trau		Down GoyiL, FR. 20a. Method of Disposition	END	9242Hz	ENAI CI	-01	BIA, 24	ocation - City or To	
Baltimore	permit. Pages Dependent of Importent: If It any injury or c		1 Burial 2 Cremation 3 L 4 Donation 5 Other (Specify 21. Signat of Fulls Service Lie	Removal from State	cemetery, crematory TOMYGIFTS	RERISTRY	5-25-0	7 HAN	NER A	
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	rate be executed  hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t						"U Cays
P.O. Box 6	The law requires that the death certific tie has been signed by the atlending p bage 2 should be deteched for use es	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	il death 3 □Ectop	ic pregnancy r (specify)			23d. Date of delive Month	ery Day Year
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Division of Vital Records,	in: The law r flicate has be or, page 2 sh	e Completed	25. Was case referred to medical		_		1,2	a. Was an autopsy performed?  Yes 2 \( \sqrt{N} \) No	24b. Were auto prior to col death? 1 \( \text{Yes} \)	ppsy findings available mpletion of cause of
<b>&gt;</b>	lysicia lis cert direct	To B	examiner?	Hospital: 1 Mnpatient 2 🗆	ER/Outpatient 3	Oth	lace of Death (Chec Nursing Home 5)		5 □Other (Specifi	iv)
sion o	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2	28d. De	escribe how injur		
DIX.	itel or At ars after d ral Direct lled in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ý) 		City	y or Town, State		
	the Hosp hin 24 hou the Fune hpletely fi	ledical	one) 2 Medical Exams	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death occur tion and/or investiga	tion, in my opinion,	death occurred at th	e to the cause(s) to time, date and	and manner as si place, and due to	tated. ) the cause(s)
	vit o	Σ	29b. Signature and title of certifier	2500 m	,	P185			e signed (Month,	
	12		Any S Roc	ompleted cause of death (Item	, 22	S. Gver	ne 87.	Bal	house	,2007 MDZ1Z4
	Sta	te	-51. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	19				

			1-Affend #4a Per P	State of Marylar hy G867 5/25/0	nd / Department of <b>JH</b> Certificate of	f Health and M of Death		ne No.2017	15985
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	/Medi		MARY	FRANCE:			May !	18, 2007	1235PM
	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number) Road	4b. City, Town	n, or Location of Death		4c. County of Death	10.
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.			8. Date of Birth	9. Birtho	place (State or Foreign
	Director		214-22-4877	1□M 212/F S	Yrs. Months Da	ys Hours Min.	FEB. 28	1923 P91	RVI AND
	and	]	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ly, Town or Location		/		0d. Inside City Limits
	Maryi f sho ied al	jo	MADWANA	10	Bn	1 TIME	DE A.	71/	1 Yes 2 □ No
	h the r 28a	Director	10e. Street and Number	7/1	10f. Zip Cod	e	10g.	Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show r.must be notified at		3933 CED,	ARDALE KO	AD	2121	5	115F	7
	er des items ner m	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
)36	urs aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2 No If Yes, Give Year or Dates:	1 □ Yes 2 🕰 🕻	No Specify:		Specify: 3	ACK
-0ster	72 hou natura Ical E	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Decedent's Usual Oc	cupation	168	o. Kind of Business/Inc	dustry
2121	vithin ne. han "	lg I	Elementary/Secondary (0-12)	College (1-4or 5+)		ne during most of worki lired)	1 244	n.,	
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Las	t)	ENVIRONMENTA		OKKER (First, Middle, Maid	den Surname)	K
Marylan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	SAMUEL	T	ORDAN	HENR	ETTA	HA	PKINS
12 Jary	2 shou and N Is man	1	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Stre	eet and Number or Rura	al Route Number, Ci	ity or Town, State, Zip	Code)
	fealth m 27 her tr	1 3	FRANCES WILS	ON (DAUGHTER	2503 H	OLLINS 5	T. BAL	TIHORE M	0.21223
Dec.' altimore,	ages 'nt of h		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	☐Removal from State	Place of Disposition (Name of cemetery, crematory or other p	olace)	Date 200	Location - City or To	wn, State
Ø ∰	nit. Prantme ortani injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	1//2	22. Name and Ad	EME: 00 -0	19-01 L	AUREL. M.	TARYLAND
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Вох	leath certifics attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	ancy Il death 3⊟Ectopic pregna			23d. Date of delive	ry
.O. B	at the dear by the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d				Month	Day Year
9.	that the ed by detacl		Part II. Other significant conditions	 contributing to death but not res	ulting in the underlying cause	given in Part I.	23e. Did tohaco	o use contribute to the	e cause of death?
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ō	ding Physi h. After this c funeral dire	<u>구</u>	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	Errodipatient 3 DOA		ne 5 MResidence 28d. Describe how in	6 Other (Specify	")
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<u>×i</u>	r Atte er dea irecto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factory, offic	ce 2	28f. Location (Street City or Town, St	and Number or Rura	Route Number,
	pital o urs aff eral D		one or the second of the secon	1		1		, 	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Property 2 Medical Example 1	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wiedge, death occurred at the tion and/or investigation, in m	e time, date and place, a ly opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Lice	ense number	29d.	Date signed (Month, I	Day, Year)
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<del>-</del>	5	-	30. Name and address of person who			Bus Ro	som w		12.20
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10ex19b Rear M Cost >/31/0/ LE Certificate of Death Reg, No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May **Physician** Year 0932 AM 2007 Francis Joseph Harney /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE n/a 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**™**M 2□ F Director 212-24-7692 New Jersey 9/15/27 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director 1 ☐ Yes 2 No MD Baltimore Halethorpe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r 916 Winsap 21227 Funeral Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No 2 Specify: Specify: 3 ₩Widowed 4 Divorced II WW White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Home Improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William James Harney Dorothy Chivers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
914 Winser Court Halethorpe, Maryland 2122 Brenda Harney / Daughter Halethorpe, Maryland 21227 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Loudon 5/25/07 Park Cemetery Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or corplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e2050 liseas-e /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s 24a. Was an autopsy perform certificate Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ️ ER/Outpatient 3 □ DOA 1 ☐ Inpatient Medical Certification: To Division or this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending Natural 2 \(\) Accident n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Function

completely f (Check only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2007 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Registrar's Signature

07-03862 Juanita Garrett

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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xamine		Juanita Garrett			1	May 21, 2007	, , , , , , , , , , , , , , , , , , , ,	1205 hrs		
	4	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of [	Death		
		203 Herring Court		Baltimore			Balti	moro		
	7	5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Yea	If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY)	9. Birthplace (State or		
neral ector	- 1			Months Day	Hours Min.	7		Country) MD		
EGLOI	L	214-48-1157 1 M 2XF 57	Yrs	S		Aug.14	,1949	MD		
	-	Usual Residence of Decedent	*	N				10d. Inside City Limits		
any		10a. State 10b. County 10c. City,	Town or Loca	tion				1 XYes 2 No		
show Ce.	_	MD Baltimore	Ba l	timore				1 Xies 2 No		
ga-f.	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What	: Country?		
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		203 Herring Court  11 Marital Status 12. Was Decedent Ever in U.	S 13 W		∠ ∆ ⊥ spanic Origin? ( Sp		J.S.A. 14. Race -	American Indian, Black,		
t be	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?			, Mexican, Puerto		White,			
or it	۶I	1 Yes 2 X No		·		•	0-114			
ie i	<u>à</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 XNo			Specify:	Black		
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than edical	립	10th	House	ekeeper			Meridi	an nursing h		
dygrem other the M	Completed	17. Father's Name (First, Middle, Last)			18.Mother's Name	(First, Middle, Maid	len Surname)			
	8	Lester Evans			Virgi	nia W	illiam	ıs		
Mental marked c event,	٥٢	19a. Informant's Name/Relationship (Type, Print )	19b. Mailir	ng Address (Stre	et and Number or F	nia W Rural Route Number	, City or Town,	State, Zip Code)		
27 is n matic	-	Nikolai Garrett/son	302	F 23 1	/2 St	Ralto I	4d 212			
of Health a If item 27 Ier traum	ŀ	20a Method of Disposition 20b.	Place of Dispo	sition (Name of ce		Date 2		City or Town, State		
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Department of Health a Important: If item 27 injury or other traum:	ı	21. Signature of Funeral Service Licensee	22.	Name and Addres	s of Facility	CC DUNE	7 T T T T T T T T T T T T T T T T T T T	MT		
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miner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the condition resulting in death)		00000						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year Hottman Elizabeth Yay 18 /Medical 2007 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 4c. County of Death Hopkins Baltimore Johns Hospital City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F 213-18-1643 Yrs. Director 87 Feb 9, Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Harford Director Havre de Grace 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Congress Avenue #70 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ white Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnetic appropries. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) James E. Monroe Elizabeth M. Crussee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karla McDonald/daughter 3412 Merle Drive Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sicolur of Euneral S rvice Licentede, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part, Enter the disease, or comshoot, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary
Due to (or as a consequence of): Physician 20 min /Medical Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RESTITION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Diadetes Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death signed by the e 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2,000 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No hes autopsy 2 No Vital 1 Yes Hospitel or Attending Physicien: Director: After this certification by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ þ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural complication 5 Pending of hear death. May 18200 1240 M 2 Accident 1 Yes 2 No investigation catheterizating heart 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide h ospital

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours e To the Funerel L Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) D41846 May 18 2007 David R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar David

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

600 N. Wolfe St. Baltimore 21287

Registrar

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29a. Certifier

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29b. Signature and title of certifier

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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29d. Date signed (Month, Day, Year)

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $20^{\text{Bay}}$ **Physician** Month 2007 Reginald W. Hebb May 6:00 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heartlands Assisted Living Severna Park <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F Director 112-20-0119 17 1918 | New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must be once. Funeral 1463 Theis Drive 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: \$ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Baltimore City 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hebb ၉ Jane Ann O'Driscoll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne H. Defeo (Daughter) 505 Silverbark Court, Millersville, Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1. Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 05/24/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EFFUSIONS **Physician** ULMOMAY NOW ITTS resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an has e 2 autopsy perform certificate has 20 No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Others is Living 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/X Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 6 ☐Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral DI completely filled in

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records, To the Hospital

Baltimore, Maryland 21215-0036

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DHMH 17 Rev 1/2001

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Medical

29a. Certifie

Signature ar

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Medical

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**ORIGINAL** 

32. Registrar's Signature

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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29d. Date signed (Month, Day, Year)

completely filled in by the funeral To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) 16 State Registrar **ORIGINAL** 

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Funeral		5. Social Security Number 6.	Sex	7. Age (li	n yrs. Ias	t birthday)	If Under		If Under 24Hr	_	te of Birth(	MM/DD/\	Foreign	thplace (State or
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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentail Hygiene Important: If item 23s narked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 X Never Married 2 Mari	A =====	Decedent Eved Forces?	er in U.S	. 13. Was	Decedent es, specify	of Hisp Cuban,	anic Origin? ( S Mexican, Puert	Specify Yoo o Rican,	es or No- etc.)		Race - Ame White, etc.	rican Indian, Black,
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Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr	1	1 X Burial 2 Cremation	3 Remov	val from State	cr	ematory or oth	ner place)		·					
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Division of Vital Records, P.O. Ital or Attending Physician; The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ဥ	1 ✓ Yes 2 No 27, Manner of Death		Inpatien  Date of Injury (Month, Day, Yes		ER/Outpatien 28b. Time of		OA 8c. Inju	ry at Work?		Describe h			101.
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ViSic or Atte fter des birecto	ifica		tigation 28e			ome, farm, stre		office b	building, etc.	28f	ocation (S	treet and	Number or	Rural Route Number, C
Dispital concerns alours alours al	Certification:	4 Homicide deter			esider					35,	29 Wood	lring	Ave. B	altimore, MD
		29a. Certifier 1 Certifying Phone) 2 ✓ Medical Example	niner:On the b	basis of exam	knowled ination a	ge, death occu ind/or investiga	irred at the ation, in my	time, do	ate and place, and place, and death occurre	and due t ed at the	o the causi time, date a	e(s) and and place	manner as s e, and due to	tated. the cause(s)
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		my ww	, mi	>				O.C.	M.E.			May '	19, 2007	
		30. Name and address of person				23a)	ot Balti	noro	MD 21201					
Q	-		nt Medical	Examiner Registrar			et, baiti	nore,	MD 21201					
Sta Registi		MAY 2.5.2	007	Se ve	N	A DOLL	<u>~_</u>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No .. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:15 AM  $_{\rm M}$ May 23, 2007 Grace Gordon Hav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6202 Welshire Place Upper Marlboro Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** MO Country) Days Months 1 ☐ M 2 1 F 90 Hours Min. 01/30/1917 492-16-3899 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits notified at Director 1 ☐ Yes 2 No MD Prince Georges Upper Marlboro 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Examiner must be 20772-USA 6202 Welshire Place Funeral tems Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "-any linjury or other traumatic event." Black, White, etc. 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: Caucasian 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Advertising Elementary/Secondary (0-12) College (1-4or 5+) Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Freeman James B Gordon ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Bradley/Son-in-law 6202 Welshire Place Upper Marlboro, MD 20772-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 25 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland 2007 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee mo1358 22. Name and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer of the Lung with Metastasis **Physician** Months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 20 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 22 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ofte) Hospital: Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) nours after death.

neral Director: After this filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I To the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

90

30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print) Wisotsky MD 12070 Old Line Ctr Waldorf MD 20602

31. Date filed (Month, Day, State

29b. Signature and title of certifier

32 Registrar's Signatur

29c. License number

D18545

29d. Date signed (Month, Day, Year)

05-24-2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND THE PROPERTY OF THE State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Sammie **Physician** James Month Year 1410PM Samuel 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Bayview Med Center

6. Sol 7. Age (In yrs. last birthday NA Baltimore Johns Hopkins 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 → M 2 □ F 226-36-1656 Director 3-5-1928 S.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore Md. Turner Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Glenardmiddleton Ct. 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Co. Elementary/Secondary (0-12) College (1-4or 5+) Paul J. Rock Construction Worker Unkn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Maggie Hoyt ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,\,21221$ 115 Glenardmiddleton Ct., Turner Station, Md Wife Irene James 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem. Pk. 5-24-07 Arbutus, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 Md. Milla 1101 E. North Ave., Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COPD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has t irector, page 2 s autopsy 1∐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours afte To the Funeral Dil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kiyatkin 4940 Easiern Ave, Baltimore, MD. 21224 E. MD 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 05 **Physician** 23 2007 1:20p<sup>M</sup> Elizabeth Duckham Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 326 Bee Tree Rd. Parkton Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 6. 3-1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2×F 220-50-4713 81 Yrs. Wales Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hyglene. Importent: If item 27 ie marked other then "naturel', or liems 23a or 28a-f ehow empt injury or other treumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 No Baltimore Parkton MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 326 Bee Tree Rd. 21120 USA Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Nes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert James Duckham Elizabeth Strickland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Hansen/daughter 702 Chumleigh Rd.Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 5/25/07 Beltsville, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. pro1358 TOWSON MP 21286 Cremation+Funeral Atternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Metastate **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certilicate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funerel Director: After this completely filled in by the funeral dir 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

Registrar

0

State

301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lliam

31. Date filed (Month, Day, Year)

Lann

320 Registrar's Signature

		For State Registrar		nd / Departn	nent of Health and cate of Death	•		007	10007
ê Divisi	4	Decedent's Name (First, Middle, Last	) –			2. Date of I	to all	Year	3. Time of Death
Physic /Medi		HATTIE		OHNSO	10	05	22		11:10 AM
Exami	ner	4a. Facility Name (If not institution, give	/	7	City, Town, or Location of Dea	~~	4c. C	ounty of Death	<i>t</i> .
Funeral Director		LE VINDALE - HEBREM         5. Social Security Number       6. Se         212 - 18 - 8850       10         Usual Residence of Decedent			Inder 1 Year If Under 24 Hr hths Days Hours Mir	s. 8. Date of B	irth Day, Year)	9. Birthp Coun ID NORT	
ID C I C I S-CUSO  filed within 72 hours after death with the Maryland Hygiene.  ther than "natural", or Itame 23a or 28a-1 show int, the Medical Examinar must be notified at	ctor	10a. State 10b. County  MARYLAND W	10c. C		BALTI MORE	City	(	1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
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d within 72 hours after of glene. Br than "natural", or Ital. The Medical Examination	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		specify Cuban, Mexican, Pue es 2 No Specify:	rto Rican, etc.)		Black, White,	etc. ACK
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12 mg mg mg mg mg mg mg mg mg mg mg mg mg	•	19a. Informant's Name/Relationship (7)  HILDA MCKNIGH 20a. Method of Disposition  15 Purish a Disposition a 2 Dis	HT DAUGHTER 200.	19b. Mailing Ad	dress (Street and Number of B BRIGHTON (Name of or other place)	Rural Route Num Dage	LTIM	own, State, Zip	2.21216
permit. Pages 1 a Department of Hee Important: If Item any injury or othe		1  Burial 2  □ Cremation 3  □ F 4  □ Donation 5  □ Other (Specify)  21. Signature of Funeral Service Licens	AR	BUTUS	1	-26-07 enun	JR. FO	HORE	HARYLAN L HOME
1 40F#9		Wietich !	V. William	no 21	40 N. FULT	ONAVO	E, BA	LTIMORE	MD21217
Physician /Medical	*	23a. Part1. Enter the disease, or compliance, or heart failures. List only of immediate Cause (Final disease or condition resulting in death)	incations that caused the deal ne cause on each line.  TERM 1  Due to (or as a consec	NAL	Dement		arøest,		Approximate Interval Between Onset and Death
ate be executed ysician and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect						
leath certificate attending phys	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3. 23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		pic pregnancy		230	d. Date of delive	•
at the dea by the at tached fo	ysici	1 Yes 2 No	4□Pregnant at time of o	death 5 Othe	or (specify)			Month	Day Year
- E - D - B	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underly	ing cause given in Part I.		tobacco use		e cause of death?
sician: The law requires to certificate has been signerector, page 2 should be of	Completed					24a. Wa aut per 1 \( \text{Yes}	opsy formed?	24b. Were autoprior to condeath?	psy findings available inpletion of cause of
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To the Hospital or within 24 hours af To the Funerel D completely filled in	edical	one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	rred at the time, date and plac ation, in my opinion, death occ	e, and due to th urred at the time	e cause(s) ar o, date and pl	nd manner as st ace, and due to	ated. the cause(s)
To the to the total	Σ	29b. Signature and title of certifier	000		29c. License number			igned (Month, I	
		· Jan	WD		D006453	3	0,9	> 22	7007
3		30. Name and address of person who co	ompleted cause of death (Iter		2434 W. BE	-HCBRG	W 46	PATRIC	- CENTER
St	ate :	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		17.67	- TVt	BALLIN	NOTHE, MIJA121
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			1 - For Amend Items	State of M 27,28a-f	aryland <b>per ग</b>	/ Depa <b>e, 28</b> 6	artment of 1	lealth Death	and Me	ntal Hy	giene Reg. No:	007	16993
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The said	/Medi	cal	5 PLVIA  4a. Fecility Name (If not institution, gir				4b. City, Town, o	r Location		nor	3	フロンク County of Dear	10 M
	Examir	ıer	GOOD SAMARITAN H				BALTIMO		or boati		N		
5	Funeral		Social Security Number     6.3		ge (In yrs. la:		If Under 1 Year Months Days	If Under Hours	Min.	Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreign
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	ryland thow	_	10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. fnside City Limits
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	death ms 2:	nera	11. Marital Status	12 Was Decedent	Ever in II S	13.	Was Decedent of H		igin? (Speci	fy Yes or No	. 1	4. Race - Ame	
36	s after	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X	No	1	1 ☐ Yes 2 🛣 No	Specify:		Dan, etc.)		Black, Whit Specify: Wh	e, etc. ITE
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Baltimore,	0 0		20a. Method of Disposition  1 XBurial 2 Cremation 3		HA	R SIN	sition (Name of natory or other place	ce)	Dat			cation - City or	
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ä	Depa Impo any i		> Yay (lla	Ju-			8900 REI	STERS					, MD 21208
· Ke			23a. Part1. Enter the disease, or conshock or heart failure. List only	nofigations that caused one cause on each li	d the death. ne.	Do not ente	er the mode of dyin	ng, such as	cardiac or r	espiratory ar	rest,		Approximate fnterval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. SUDDI			WIVM						5 DMS
	Examiner		1	Due to (or as	a conseque	nce of):				//	//		
	p i	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	nce of):			4	ED BY MEDIC	AL EXAMIN	TER	
	xecute and il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseque	nce of):		J	NV I	ED BY MEDIC			
8760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	cal E	(	ď.	, , ,			CERTIFICA	FIGH W				
89	rtificate ng phys as the	Physician/Medical	fF FEMALE:										
Вох	leath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	eath 3	Ectopic pregnancy	,			23	3d. Date of del	ivery Day Year
P.O.	at the de by the a teched	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of dea	tn 5	Other (specify)						
S,	res that igned b	by Pi	Part ff. Other significant conditions	contributing to death b	ut not resulti	ng in the un	nderlying cause giv	en in Part I		23e. Did to	bacco us	se contribute to	the cause of death?
ord	w require been si should b	ted	STRUKE							1 🗆 Y	es 2	No 3□Pr	obably 4 Unknown
Rec	The law cate has b page 2 sl	Completed	ZITTE SWVB LINGTH	L DISEASE						24a. Was autop		24b. Were au prior to death?	topsy findings available completion of cause of
ta	ilcian: Th certificate rector, pag	0	25. Was case referred to medical					26 Place	of Death (	1 ☐ Yes Check only o	2 No	1 ☐ Yes	2 No
Ţ	nyslcian: nis certific I director.	To B	examiner? 1 X Yes 2 □ No	Hospital: fnpatie	ent 2 EF	VOutpatien	t 3 DOA Oth	or				Other (Spec	cify)
Division of Vital Records,	Attending Physician: or death. ector: After this certifice by the funeral director.		27. Manner of Death  Sinatural 5 Pending	28a. Date of Inju (Month, Da		Bb. Time of fnjury	D. 28c. Injun Worl		Stri	d. Describe h			wheelchair
/isic	l or Attendi after death. Director: A i in by the fu	ficat	2 Accident investigatio 3 Suicide 6 Could not be determined	990 Place of Ini		2:0 e, farm, stre	eet, factory, office	Yes X	28	Location (S	Street and	Number or Ri	ural Route Number
Ö	i Si i	Certification:	4 Homicide determined	building, et	c. (Specify) ing Ho		,		11:	5 E. M	elro	se Ave.	,Balto.,MD
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best miner: On the basis of and manner sta	f examination	edge, death n and/or inv	occurred at the tin restigation, in my o	ne, date an pinion, dea	id place, and th occurred	d due to the d at the time, d	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
5	within To th	Ň	29b. Signature and title of certifier	222			29c. Licenso		,			signed (Monti	
			> /m/m ///	עזייי		0.1.7		120		,	VA	13,3	LUVI
	Market and the		30. Name and address of person who	WII 57	oui L	0641	roven B	WD,	sor	monc	in	021	239
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 3 2007	32. Registr	ars signatur	certi	P						

			1 - For State Registrar	State of Marylan		artment of H			giene Neg. No.	37	5999		
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Y <u>e</u> ar 3	Time of Death		
	Physicia /Medic	al l	Betty		Le				21 20	07	1614 <sup>M</sup>		
	Examin		4a. Facility Name (If not institution, give str 5906 Plainfiel	d Avenue		Balt	imore			NA			
	Funeral Director		218-48-48/8	7. Age (In yrs.	8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da)	, Year) -1948	9. Birthplace Country)	(State or Foreign		
	tand ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d.	Inside City Limits		
	Many Feb	tor	Md. NA		Ba	ltimore					1 XYes 2 □ No		
	with the	Director	10e. Street and Number 5906 Plainsfiel	d Avenue		10f. Zip Code 212	06		10g. Citizen of V USA	-			
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental thygiene. Item 27 Ie marked other then "neturel; or Iteme 23a or 28e-f ehow other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 12	. Was Decedent Ever in U. Armed Forces? 1	i	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 21x No	ispanic Origin? (Sin, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Rac Blac Specify	e - American I ck, White, etc.			
21215-0036	"neture!",	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa (Specify only highest grade of	tion	16a Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of B				
2121	d withir giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		ecurity	Guard		Vari				
Maryland	nould be filed I Mental Hygid narked other natic event, ii	Be	17. Father's Name (First, Middle, Last)  Euddie	Bratcher			18. Mother's Nan	_		ne) Brooks			
aryl	2 should be and Mental le marked (aumatic ev	ဥ	19a. Informant's Name/Relationship (Type			ng Address (Street							
	1 and 2 Health a em 27 le		Anthony Bratche	r Son		6 Plains		the state of the s					
Baltimore,			20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)			esition (Name of matory or other place em. Par)		Date 26-07		allsto	wn, Md.		
Balt	permit. Pages Depertment of Important: If I any Injury or once		21. Signature of Funeral Service Licensee	Cane		2. Name and Address 1101 E.	North	Ave., E			d. 2120		
760,	Physician /Medical Examiner and parial-transit per purial-transit per purial-transit per per per per per per per per per per	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of the consequence of t	y d de	ma n Diai	th						
P.O. Box 68	The law requires that the deeth certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	ysiclan/Med	nysiclan/Med	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	I death 3	□Ectopic pregnancy	,			ite of delivery onth Da	y Year
	luires that n signed b	þ	Part II. Other significant conditions control	ibuting to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use con Yes 20 No	tribute to the d			
Vital Records,		Completed	Migra	nea				24a. Was autoj perfo 1 🗆 Yes	osy irmad?	Were autopsy prior to compleath?	findings available et on of cause of No		
Vita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	spital:	150/0 to 15	oth		ath Check only o	one) dence 6⊟Ott	nos (Casalta)	7)		
ō	y sign	n: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury				how injury occur	(-)			
Division	To the Hospital or Attending F within 24 hours after deeth.  To the Funeral Director: After completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	M 1 🗆	Yes 2 □ No	28f. Location ( City or To	Street and Num wn, State)	ber or Rural R	oute Number,		
_	Hospital     24 hours a     Funeral letely filled	Medical Ce	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine one)	cian: To the best of my know: Or: On the basis of examination and manner stated.	owledge, deal	th occurred at the till evestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as state , and due to th	ed. e cause(s)		
	To th within To th	Me	29b. Signature and title of certifier	well M.C	)	29c. Licens	601541		29d. Date signe	3/07			
	4		30. Name and address of person who con	VGUTEN,	6331	Bela	irRd	Bultin	nne M	12	1206		
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 5 2007	32. Registrar's Sign	ature	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Emma Jane Leitz 9:00 A May 21 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 817 Whitewood Trail Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🙀 F 75 215-28-2920 10/16/1931 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Crownsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 817 Whitewood Trail 21032 USA Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3√ Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Dietitian Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percey Neat Anna Frebertshauser ie marked ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health ? Thelma Furlong / Daughter 822 Birch Trail, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: ff any injury of once. Meadowridge Memorial Park 05/25/2007 Elkridge, MD <sup>22. Name and Address of Facility</sup>
Gary L. Kaufman Funeral Home at MMP,
7250 Washington Blvd., Elkridge, MD 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bet Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months2 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 hes autopsy performed 1 TYes 2 1 2 🗓 funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 Ne 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 Watural 5 Pending i efter death.
i Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai within 24 hours e To the Funerail pelli 1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely f 29d. Date signed (Month, Day, Year) 29b. Signature and 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 5 2007 Registrar